LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES, 2000 ($000)	FY 1999 Comparable	FY 2000 Request	House	Senate	Conference	Conference vs FY 1999	Conference vs House	Conference vs Senate	Mand Disc
TITLE IV - RELATED AGENCIES									
ARMED FORCES RETIREMENT HOME									
Operations and Maintenance	55,028	55,599	55,599	---	55,599	+571	---	+55,599	D
Capital Program	15,717	12,696	12,696	---	12,696	-3,021	---	+12,696	D
Total, AFRH	70,745	68,295	68,295	---	68,295	-2,450	---	+68,295	
CORPORATION FOR NATIONAL AND COMMUNITY SERVICE (1)									
Domestic Volunteer Service Programs:									
Volunteers in Service to America (VISTA)	73,000	81,000	73,000	81,000	81,000	+8,000	+8,000	---	D
National Senior Volunteer Corps:									
Foster Grandparents Program	93,256	95,000	93,256	95,000	96,354	+3,098	+3,098	+1,354	D
Senior Companion Program	36,573	39,031	36,573	39,031	39,369	+2,796	+2,796	+338	D
Retired Senior Volunteer Program	43,001	46,001	43,001	46,001	46,293	+3,292	+3,292	+292	D
Senior Demonstration Program	1,080	5,000	---	3,100	1,500	+420	+1,500	-1,600	D
Subtotal, Senior Volunteers	173,910	185,032	172,830	183,132	183,516	+9,606	+10,686	+384	
Program Administration (2)	29,929	33,500	29,129	29,129	31,129	+1,200	+2,000	+2,000	D
Total, Domestic Volunteer Service Programs	276,839	299,532	274,959	293,261	295,645	+18,806	+20,686	+2,384	

(1) Appropriations for Americorps are provided in the VA-HUD bill (P.L. 106-74).

(2) Includes $800,000 in emergency funding for Year 2000 computer conversion.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES, 2000 ($000)	FY 1999 Comparable	FY 2000 Request	House	Senate	Conference	Conference vs FY 1999	Conference vs House	Conference vs Senate	Mand Disc
CORPORATION FOR PUBLIC BROADCASTING:									
FY02 (current request) with FY01 comparable	340,000	350,000	340,000	350,000	350,000	+10,000	+10,000	---	
FY01 advance with FY00 comparable (NA)	(300,000)	(340,000)	(340,000)	(340,000)	(340,000)	(+40,000)	---	---	NA
FY00 advance with FY99 comparable (NA)	(250,000)	(300,000)	(300,000)	(300,000)	(300,000)	(+50,000)	---	---	NA
Digitalization program (1)	15,000	20,000	10,000	---	10,000	-5,000	---	+10,000	D
Satellite replacement supplemental--FY99	30,700	---	---	---	---	-30,700	---	---	D
Satellite replacement supplemental--FY00	17,300	---	---	---	---	-17,300	---	---	D
Advance from prior year	---	(17,300)	(17,300)	(17,300)	(17,300)	(+17,300)	---	---	NA
Subtotal, FY00 appropriation	(295,700)	(337,300)	(327,300)	(317,300)	(327,300)	(+31,600)	---	(+10,000)	
FEDERAL MEDIATION AND CONCILIATION SERVICE	34,620	36,834	34,620	36,834	36,834	+2,214	+2,214	---	D
FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION	6,060	6,159	6,060	6,159	6,159	+99	+99	---	D
INSTITUTE OF MUSEUM AND LIBRARY SERVICES	166,175	154,500	149,500	154,500	166,885	+710	+17,385	+12,385	D
MEDICARE PAYMENT ADVISORY COMMISSION (TF)	7,015	7,015	7,015	7,015	7,015	---	---	---	TF
NATIONAL COMMISSION ON LIBRARIES AND INFO SCIENCE	1,000	1,300	1,000	1,300	1,300	+300	+300	---	D
NATIONAL COUNCIL ON DISABILITY	2,344	2,400	2,344	2,400	2,400	+56	+56	---	D
NATIONAL EDUCATION GOALS PANEL	2,100	2,250	2,100	2,250	2,250	+150	+150	---	D
NATIONAL LABOR RELATIONS BOARD	184,451	210,193	174,661	210,193	206,500	+22,049	+31,839	-3,693	D
NATIONAL MEDIATION BOARD	8,400	9,100	8,400	9,100	9,600	+1,200	+1,200	+500	D
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION	8,100	8,500	8,100	8,500	8,500	+400	+400	---	D

(1) Unauthorized. Funding is subject to enactment of authorization by September 30, 1999 and 2000.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES, 2000 ($000)	FY 1999 Comparable	FY 2000 Request	House	Senate	Conference	Conference vs FY 1999	Conference vs House	Conference vs Senate	Mand Disc
RAILROAD RETIREMENT BOARD									
Dual Benefits Payments Account	189,000	175,000	175,000	175,000	174,000	-15,000	-1,000	-1,000	D
Less Income Tax Receipts on Dual Benefits	-11,000	-10,000	-10,000	-10,000	-10,000	+1,000	---	---	D
Subtotal, Dual Benefits	178,000	165,000	165,000	165,000	164,000	-14,000	-1,000	-1,000	
Federal Payment to the RR Retirement Account	150	150	150	150	150	---	---	---	M
Limitation on administration: Consolidated Account (1)	90,398	86,500	90,000	90,000	91,000	+602	+1,000	+1,000	TF
Inspector General	5,600	5,400	5,400	5,400	5,400	-200	---	---	TF
SOCIAL SECURITY ADMINISTRATION									
Payments to Social Security Trust Funds	19,689	20,764	20,764	20,764	20,764	+1,075	---	---	M
SPECIAL BENEFITS FOR DISABLED COAL MINERS									
Benefit payments	542,183	520,000	520,000	520,000	520,000	-22,183	---	---	M
Administration	4,620	4,638	4,638	4,638	4,638	+18	---	---	M
Subtotal, Black Lung, current year program level	546,803	524,638	524,638	524,638	524,638	-22,165	---	---	
Less funds advanced in prior year	-160,000	-141,000	-141,000	-141,000	-141,000	+19,000	---	---	M
Total, Black Lung, current request	386,803	383,638	383,638	383,638	383,638	-3,165	---	---	
New advances, 1st quarter FY01	141,000	124,000	124,000	124,000	124,000	-17,000	---	---	M

(1) Includes $398,000 in emergency funding for Year 2000 computer conversion.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES, 2000 ($000)	FY 1999 Comparable	FY 2000 Request	House	Senate	Conference	Conference vs FY 1999	Conference vs House	Conference vs Senate	Mand Disc
SUPPLEMENTAL SECURITY INCOME									
Federal benefit payments	28,263,000	28,822,000	28,822,000	28,822,000	28,822,000	+559,000	---	---	M
Beneficiary services	61,000	64,000	64,000	64,000	64,000	+3,000	---	---	M
Research and demonstration	37,000	24,000	24,000	25,085	25,085	-11,915	+1,085	---	M
Administration	2,114,000	2,203,000	2,114,000	2,192,000	2,142,000	+28,000	+28,000	-50,000	D
Subtotal, SSI current year program level	30,475,000	31,113,000	31,024,000	31,103,085	31,053,085	+578,085	+29,085	-50,000	
Less funds advanced in prior year	-8,680,000	-9,550,000	-9,550,000	-9,550,000	-9,550,000	-870,000	---	---	M
Subtotal, regular SSI current year (1999/2000)	21,795,000	21,563,000	21,474,000	21,553,085	21,503,085	-291,915	+29,085	-50,000	
Additional CDR funding (1)	177,000	200,000	200,000	200,000	200,000	+23,000	---	---	D
User Fee Activities	75,000	80,000	80,000	80,000	80,000	+5,000	---	---	D
Total, SSI, current request	22,047,000	21,843,000	21,754,000	21,833,085	21,783,085	-263,915	+29,085	-50,000	
New advance, 1st quarter, FY01	9,550,000	9,890,000	9,890,000	9,890,000	9,890,000	+340,000	---	---	M

(1) Two year availability.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES, 2000 ($000)	FY 1999 Comparable	FY 2000 Request	House	Senate	Conference	Conference vs FY 1999	Conference vs House	Conference vs Senate	Mand Disc
LIMITATION ON ADMINISTRATIVE EXPENSES									
OASDI Trust Funds	2,928,400	2,910,200	2,928,200	2,928,400	2,928,400	---	+200	---	TF
HI/SMI Trust Funds	952,000	1,087,000	952,000	1,066,671	1,039,671	+87,671	+87,671	-27,000	TF
Social Security Advisory Board	1,600	1,800	1,800	1,800	1,800	+200	---	---	TF
SSI	2,114,000	2,203,000	2,114,000	2,192,000	2,142,000	+28,000	+28,000	-50,000	TF
Subtotal, regular LAE	5,996,000	6,202,000	5,996,000	6,188,871	6,111,871	+115,871	+115,871	-77,000	
User Fee Activities (SSI)	75,000	80,000	80,000	80,000	80,000	+5,000	---	---	TF
Claimant representative payments	---	19,000	---	---	---	---	---	---	TF
TOTAL, REGULAR LAE	6,071,000	6,301,000	6,076,000	6,268,871	6,191,871	+120,871	+115,871	-77,000	
Additional CDR funding (1)									
OASDI	178,000	205,000	205,000	205,000	205,000	+27,000	---	---	TF
SSI	177,000	200,000	200,000	200,000	200,000	+23,000	---	---	TF
Subtotal, CDR funding	355,000	405,000	405,000	405,000	405,000	+50,000	---	---	
TOTAL, LAE	6,426,000	6,706,000	6,481,000	6,673,871	6,596,871	+170,871	+115,871	-77,000	

(1) Two year availability.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES, 2000 ($000)	FY 1999 Comparable	FY 2000 Request	House	Senate	Conference	Conference vs FY 1999	Conference vs House	Conference vs Senate	Mand Disc
OFFICE OF INSPECTOR GENERAL									
Federal Funds	12,000	15,000	12,000	15,000	15,000	+3,000	+3,000	---	D
Trust Funds	44,000	51,000	44,000	51,000	51,000	+7,000	+7,000	---	TF
Total, Office of the Inspector General	56,000	66,000	56,000	66,000	66,000	+10,000	+10,000	---	
Adjustment: Trust fund transfers from general revenues	-2,366,000	-2,483,000	-2,394,000	-2,472,000	-2,422,000	-56,000	-28,000	+50,000	TF
Total, Social Security Administration	36,260,492	36,550,402	36,315,402	36,519,358	36,442,358	+181,866	+126,956	-77,000	
Federal funds	32,156,492	32,276,402	32,184,402	32,266,487	32,216,487	+59,995	+32,085	-50,000	
Current year	(22,465,492)	(22,262,402)	(22,170,402)	(22,252,487)	(22,202,487)	(-263,005)	(+32,085)	(-50,000)	
New advances, 1st quarter FY00	(9,691,000)	(10,014,000)	(10,014,000)	(10,014,000)	(10,014,000)	(+323,000)	---	---	
Trust funds	4,104,000	4,274,000	4,131,000	4,252,871	4,225,871	+121,871	+94,871	-27,000	
UNITED STATES INSTITUTE OF PEACE	12,160	13,000	12,160	13,000	13,000	+840	+840	---	D
Total, Title IV, Related Agencies	37,717,649	37,996,530	37,675,166	37,874,420	37,887,291	+169,642	+212,125	+12,871	
Federal funds	33,510,636	33,623,615	33,441,751	33,519,134	33,558,005	+47,369	+116,254	+38,871	
Current year	(23,462,336)	(23,259,615)	(23,087,751)	(23,155,134)	(23,194,005)	(-268,331)	(+106,254)	(+38,871)	
Advance Year, FY01	(9,708,300)	(10,014,000)	(10,014,000)	(10,014,000)	(10,014,000)	(+305,700)	---	---	
Advance Year, FY02	(340,000)	(350,000)	(340,000)	(350,000)	(350,000)	(+10,000)	(+10,000)	---	
Trust funds	4,207,013	4,372,915	4,233,415	4,355,286	4,329,286	+122,273	+95,871	-26,000	
TITLE X									
Agriculture Disaster Emergency	---	---	508,000	---	---	---	-508,000	---	D EMG

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES, 2000 ($000)	FY 1999 Comparable	FY 2000 Request	House	Senate	Conference	Conference vs FY 1999	Conference vs House	Conference vs Senate	Mand Disc
SUMMARY									
Grand bill total	301,168,146	322,958,939	318,313,930	328,612,841	328,229,885	+27,061,739	+9,915,955	-382,956	
Federal Funds	291,411,190	312,987,882	309,003,602	318,790,642	318,504,503	+27,093,313	+9,500,901	-286,139	
Current year	(241,996,850)	(259,390,821)	(245,933,536)	(255,000,205)	(256,750,065)	(+14,753,215)	(+10,816,529)	(+1,749,860)	
Advance Year, FY01	(49,074,340)	(53,247,061)	(62,730,066)	(63,440,437)	(61,404,438)	(+12,330,098)	(-1,325,628)	(-2,035,999)	
Advance Year, FY02	(340,000)	(350,000)	(340,000)	(350,000)	(350,000)	(+10,000)	(+10,000)	---	
Trust Funds	9,756,956	9,971,057	9,310,328	9,822,199	9,725,382	-31,574	+415,054	-96,817	
BUDGET ENFORCEMENT ACT RECAP									
Mandatory, total in bill	211,156,337	229,336,630	228,859,896	230,610,465	231,330,098	+20,173,761	+2,470,202	+719,633	
Less advances for subsequent years	-40,529,605	-42,791,003	-42,791,003	-42,791,003	-42,791,003	-2,261,398	---	---	
Plus advances provided in prior years	38,458,189	40,529,605	40,529,605	40,529,605	40,529,605	+2,071,416	---	---	
Unauthorized NAFTA activities	-44,000	---	---	---	---	+44,000	---	---	
Subtotal, mandatory	209,040,921	227,075,232	226,598,498	228,349,067	229,068,700	+20,027,779	+2,470,202	+719,633	
Reclassified to discretionary	321,173	---	---	---	---	-321,173	---	---	
Total, mandatory, current year	209,362,094	227,075,232	226,598,498	228,349,067	229,068,700	+19,706,606	+2,470,202	+719,633	

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES, 2000 ($000)	FY 1999 Comparable	FY 2000 Request	House	Senate	Conference	Conference vs FY 1999	Conference vs House	Conference vs Senate	Mand Disc
Discretionary, total in bill	90,011,809	93,522,309	89,454,034	98,002,376	96,899,787	+6,887,978	+7,445,753	-1,102,589	
Less advances for subsequent years	-8,884,735	-10,806,058	-20,279,063	-20,999,434	-18,963,435	-10,078,700	+1,315,628	+2,035,999	
Plus advances provided in prior years	4,008,386	8,844,735	8,844,735	8,844,735	8,844,735	+4,836,349	---	---	
Scorekeeping adjustments:									
Plus TF advances provided in prior years	40,000	---	---	---	---	-40,000	---	---	
Adjustment to balance with 1999 bill	2,824	---	---	---	---	-2,824	---	---	
Adjustment for leg cap on Title XX SSBGs	-471,000	---	-471,000	-1,330,000	-605,000	-134,000	-134,000	+725,000	
SSA User Fee Collection	-75,000	-80,000	-80,000	-80,000	-80,000	-5,000	---	---	
Puerto Rico CHIP payments	32,000	---	---	---	---	-32,000	---	---	
MN/WY Disproportionate Share Hospitals	21,000	---	---	---	---	-21,000	---	---	
Women's health and cancer rights	1,000	---	---	---	---	-1,000	---	---	
Refugee and entrant assistance reappropriation	---	12,000	12,000	12,000	12,000	+12,000	---	---	
Emergency-designated funding	-1,122,413	---	---	---	---	+1,122,413	---	---	
Freeze direct student loan admin costs	---	---	-118,000	---	---	---	+118,000	---	
Freeze HCFA payment integrety admin costs	---	---	-70,000	---	---	---	+70,000	---	
Unauthorized NAFTA activities	44,000	---	---	---	---	-44,000	---	---	
Offsets	---	---	-258,000	---	---	---	+258,000	---	
Medicaid Title XX offset	---	---	---	25,000	1,000	+1,000	+1,000	-24,000	
Subtotal, discretionary	83,607,871	91,592,986	77,034,706	84,474,677	86,109,087	+2,501,216	+9,074,381	+1,634,410	
Reclassified from mandatory	-321,173	---	---	---	---	+321,173	---	---	
Total, discretionary, current year	83,286,698	91,592,986	77,034,706	84,474,677	86,109,087	+2,822,389	+9,074,381	+1,634,410	
Crime trust fund	155,951	169,500	156,000	156,000	152,000	-3,951	-4,000	-4,000	
General purposes	83,130,747	91,423,486	76,878,706	84,318,677	85,957,087	+2,826,340	+9,078,381	+1,638,410	
Grand total, current year	292,648,792	318,668,218	303,633,204	312,823,744	315,177,787	+22,528,995	+11,544,583	+2,354,043	

The conference agreement would enact the provisions of H.R. 3425 as introduced on November 17, 1999. The text of that bill follows:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the fiscal year ending September 30, 2000, and for other purposes, namely:

TITLE I—EMERGENCY SUPPLEMENTAL APPROPRIATIONS

CHAPTER 1

DEPARTMENT OF AGRICULTURE

FARM SERVICE AGENCY

AGRICULTURAL CREDIT INSURANCE FUND PROGRAM ACCOUNT

For additional gross obligations for the principal amount of direct and guaranteed loans as authorized by 7 U.S.C. 1928–1929, to be available from funds in the Agricultural Credit Insurance Fund to meet the needs resulting from natural disasters, as follows: farm ownership loans, $590,578,000, of which $568,627,000 shall be for guaranteed loans; operating loans, $1,404,716,000, of which $302,158,000 shall be for unsubsidized guaranteed loans and $702,558,000 shall be for subsidized guaranteed loans; and for emergency loans, $547,000,000.

For the additional cost of direct and guaranteed loans to meet the needs resulting from natural disasters, including the cost of modifying loans as defined in section 502 of the Congressional Budget Act of 1974, to remain available until expended, as follows: farm ownership loans, $4,012,000, of which $3,184,000 shall be for guaranteed loans; operating loans, $89,596,000, of which $4,260,000 shall be for unsubsidized guaranteed loans and $61,895,000 shall be for subsidized guaranteed loans; and for emergency loans, $84,949,000.

EMERGENCY CONSERVATION PROGRAM

For an additional amount for the ''Emergency Conservation Program'' for expenses resulting from natural disasters, $50,000,000, to remain available until expended.

COMMODITY CREDIT CORPORATION FUND

CROP LOSS ASSISTANCE

For an additional amount for crop loss assistance authorized by section 801 of Public Law 106–78, $186,000,000: Provided, That this assistance shall be under the same terms and conditions as in section 801 of Public Law 106–78.

SPECIALTY CROP ASSISTANCE

For an additional amount for specialty crop assistance authorized by section 803(c)(1) of Public Law 106–78, $2,800,000: Provided, That the definition of eligible persons in section 803(c)(2) of Public Law 106–78 shall include producers who have suffered quality or quantity losses due to natural disasters on crops harvested and placed in a warehouse and not sold.

LIVESTOCK ASSISTANCE

For an additional amount for livestock assistance authorized by section 805 of Public Law 106–78, $10,000,000: Provided, That the Secretary of Agriculture may use this additional amount to provide assistance to persons who raise livestock owned by other persons for income losses sustained with respect to livestock during 1999 if the Secretary finds that such losses are the result of natural disasters.

NATURAL RESOURCES CONSERVATION SERVICE

WATERSHED AND FLOOD PREVENTION OPERATIONS

For an additional amount for ''Watershed and Flood Prevention Operations'' to repair damages to the waterways and watersheds resulting from natural disasters, $80,000,000, to remain available until expended.

RURAL HOUSING SERVICE

RURAL HOUSING INSURANCE FUND PROGRAM ACCOUNT

For additional gross obligations for the principal amount of direct loans as authorized by title V of the Housing Act of 1949, to be available from funds in the rural housing insurance fund to meet the needs resulting from natural disasters, as follows: $50,000,000 for loans to section 502 borrowers, as determined by the Secretary; $15,000,000 for section 504 housing repair loans; and $5,000,000 for section 514 farm labor housing.

For the additional cost of direct loans to meet the needs resulting from natural disasters, including the cost of modifying loans, as defined in section 502 of the Congressional Budget Act of 1974, to remain available until expended, as follows: section 502 loans, $4,265,000; section 504 loans, $4,584,000; and section 514 farm labor housing, $2,250,000.

RURAL HOUSING ASSISTANCE GRANTS

For the additional cost of grants and contracts for domestic farm labor and very low-income housing repair made available by the Rural Housing Service, as authorized by 42 U.S.C. 1474 and 1486, to meet the needs resulting from natural disasters, $14,500,000, to remain available until expended.

GENERAL PROVISIONS—THIS CHAPTER

SEC. 101. Notwithstanding section 196 of the Agricultural Market Transition Act (7 U.S.C. 7333), the Secretary of Agriculture shall provide up to $20,000,000 in assistance under the noninsured crop assistance program under that section, without any requirement for an area loss, to producers located in a county with respect to which a natural disaster was declared by the Secretary, or a major disaster or emergency was declared by the President under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 et seq.).

SEC. 102. Section 814 of Public Law 106–78 is amended by inserting the following after ''year'': ''(and 2001 crop year for citrus fruit, avocados in California, and macadamia nuts)''.

SEC. 103. Of the funds made available under section 802 of Public Law 106–78 not otherwise needed to fully implement that section, the Secretary of Agriculture may use up to $4,700,000 to carry out title IX of Public Law 106–78.

SEC. 104. (a) Of the funds made available under section 802 of Public Law 106–78 (excluding any funds authorized by this Act to carry out title IX of Public Law 106–78) and under section 1111 of Public Law 105–277 not otherwise needed to fully implement those sections, the Secretary of Agriculture may provide assistance to producers or first-handlers for the 1999 crop of cottonseed.

(b) Of the funds made available under section 802 of Public Law 106–78 and section 1111 of Public Law 105–277 not otherwise needed to fully implement those sections (excluding any funds authorized by this Act to carry out title IX and to provide assistance to producers or first-handlers for the 1999 crop of cottonseed under subsection (a) of this section), the Secretary may provide funds to carry out subsection (c) of this section.

(c) The Agricultural Market Transition Act is amended by inserting after section 136 (7 U.S.C. 7236), the following new section:

''SEC. 136A. SPECIAL COMPETITIVE PROVISIONS FOR EXTRA LONG STAPLE COTTON.

''(a) COMPETITIVENESS PROGRAM.—Notwithstanding any other provision of law, during the period beginning on October 1, 1999, and ending on July 31, 2003, the Secretary shall carry out a program to maintain and expand the domestic use of extra long staple cotton produced in the United States, to increase exports of extra long staple cotton produced in the United States, and to ensure that extra long staple cotton produced in the United States remains competitive in world markets.

''(b) PAYMENTS UNDER PROGRAM; TRIGGER.—Under the program, the Secretary shall make payments available under this section whenever—

''(1) for a consecutive 4-week period, the world market price for the lowest priced competing growth of extra long staple cotton (adjusted to United States quality and location and for other factors affecting the competitiveness of such cotton), as determined by the Secretary, is below the prevailing United States price for a competing growth of extra long staple cotton; and

''(2) the lowest priced competing growth of extra long staple cotton (adjusted to United States quality and location and for other factors affecting the competitiveness of such cotton), as determined by the Secretary, is less than 134 percent of the loan rate for extra long staple cotton.

''(c) ELIGIBLE RECIPIENTS.—The Secretary shall make payments available under this section to domestic users of extra long staple cotton produced in the United States and exporters of extra long staple cotton produced in the United States who enter into an agreement with the Commodity Credit Corporation to participate in the program under this section.

''(d) PAYMENT AMOUNT.—Payments under this section shall be based on the amount of the difference in the prices referred to in subsection (b)(1) during the fourth week of the consecutive four-week period multiplied by the amount of documented purchases by domestic users and sales for export by exporters made in the week following such a consecutive four-week period.

''(e) FORM OF PAYMENT.—Payments under this section shall be made through the issuance of cash or marketing certificates, at the option of eligible recipients of the payments.''.

SEC. 105. The entire amount necessary to carry out this chapter and the amendments made by this chapter shall be available only to the extent that an official budget request for the entire amount, that includes designation of the entire amount of the request as an emergency requirement as defined in the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, is transmitted by the President to the Congress: Provided, That the entire amount is designated by the Congress as an emergency requirement pursuant to section 251(b)(2)(A) of such Act.

CHAPTER 2

FEDERAL EMERGENCY MANAGEMENT AGENCY DISASTER RELIEF

Of the unobligated balances made available under the second paragraph under the heading ''Federal Emergency Management Agency, Disaster Relief'' in Public Law 106–74, in addition to other amounts made available, up to $215,000,000 may be used by the Director of the Federal Emergency Management Agency for the buyout of homeowners (or the relocation of structures) for principal residences that have been made uninhabitable by flooding caused by Hurricane Floyd and surrounding events and are located in a 100-year floodplain: Provided, That no homeowner may receive any assistance for buyouts in excess of the fair market value of the residence on September 1, 1999 (reduced by any proceeds from insurance or any other source paid or owed as a result of the flood damage to the residence): Provided further, That each State shall ensure that there is a contribution from non-Federal sources of not less than 25 percent in matching funds (other than administrative costs) for any funds allocated to the State for buyout assistance: Provided further, That all buyouts under this section shall be subject to the terms and conditions specified under 42 U.S.C. 5170c(b)(2)(B): Provided further, That none of the funds made available for buyouts under this paragraph may be used in any calculation of a State's section 404 allocation: Provided further, That the Director shall report quarterly to the House and Senate Committees on Appropriations on the use of all funds allocated under this paragraph and certify that the use of all funds are consistent with all applicable laws and requirements: Provided further, That the Inspector General for the Federal Emergency Management Agency shall establish a task force to review all uses of funds

allocated under this paragraph to ensure compliance with all applicable laws and requirements: Provided further, That no funds shall be allocated for buyouts under this paragraph except in accordance with regulations promulgated by the Director: Provided further, That the Director shall promulgate regulations not later than December 31, 1999, pertaining to the buyout program which shall include eligibility criteria, procedures for prioritizing projects, requirements for the submission of state and local buyout plans, an identification of the Federal Emergency Management Agency's oversight responsibilities, procedures for cost-benefit analysis, and the process for measuring program results: Provided further, That the Director shall report to Congress not later than December 31, 1999, on the feasibility and justification of reducing buyout assistance to those who fail to purchase and maintain flood insurance: Provided further, That the entire amount shall be available only to the extent an official budget request, that includes designation of the entire amount of the request as an emergency requirement as defined by the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, is transmitted by the President to the Congress: Provided further, That the entire amount is designated by the Congress as an emergency requirement pursuant to section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended.

TITLE II—OTHER APPROPRIATIONS MATTERS

SEC. 201. Section 733 of Public Law 106–78 is amended by striking after ''Missouri'' '', or the Food and Drug Administration Detroit, Michigan, District Office Laboratory; or to reduce the Detroit, Michigan, Food and Drug Administration District Office below the operating and full-time equivalent staffing level of July 31, 1999; or to change the Detroit District Office to a station, residence post or similarly modified office; or to reassign residence posts assigned to the Detroit District Office''.

SEC. 202. None of the funds made available to the Food and Drug Administration by Public Law 106–78 or any other Act for fiscal year 2000 shall be used to reduce the Detroit, Michigan, Food and Drug Administration District Office below the operating and full-time equivalent staffing level of July 31, 1999; or to change the Detroit District Office to a station, residence post or similarly modified office; or to reassign residence posts assigned to the Detroit District Office: Provided, That this section shall not apply to Food and Drug Administration field laboratory facilities or operations currently located in Detroit, Michigan, if the full-time equivalent staffing level of laboratory personnel as of July 31, 1999, is assigned to locations in the general vicinity of Detroit, Michigan, pursuant to cooperative agreements between the Food and Drug Administration and other laboratory facilities associated with the State of Michigan.

SEC. 203. Notwithstanding any other provision of law, the Secretary of Agriculture may use funds provided for rural housing assistance grants in Public Law 106–78 for a pilot project to provide home ownership for farm workers and workers involved in the processing of farm products in Salinas, California, and the surrounding area.

SEC. 204. Notwithstanding any other provision of law (including the Federal Grants and Cooperative Agreements Act), the Secretary of Agriculture shall use not more than $9,000,000 of Commodity Credit Corporation funds for a cooperative program with the State of Florida to replace commercial trees removed to control citrus canker until the earlier of December 31, 1999, or the date crop insurance coverage is made available with respect to citrus canker; and the Secretary of Agriculture shall use not more than $7,000,000 of Commodity Credit Corporation funds to replace non-commercial trees (known as dooryard citrus trees), owned by private homeowners, and removed to control citrus canker.

SEC. 205. (a) CONTINUATION OF REVENUE INSURANCE PILOT.—Section 508(h)(9)(A) of the Federal Crop Insurance Act (7 U.S.C. 1508(h)(9)(A)) is amended by striking ''1997, 1998, 1999, and 2000'' and inserting ''1997 through 2001''.

(b) EXPANSION OF CROP INSURANCE PILOTS.—In the case of any pilot program offered under the Federal Crop Insurance Act that was approved by the Board of Directors of the Federal Crop Insurance Corporation on or before September 30, 1999, the pilot program may be offered on a regional, whole State, or national basis for the 2000 and 2001 crop years notwithstanding section 553 of title 5, United States Code.

SEC. 206. SALES CLOSING DATES FOR CROP INSURANCE.—Section 508(f)(2) of the Federal Crop Insurance Act (7 U.S.C. 1508(f)(2)) is amended—

(1) by inserting ''(A) IN GENERAL.—'' before the first sentence;

(2) by striking the last sentence; and

(3) by adding at the end the following:

''(B) ESTABLISHED DATES.—Except as provided in subparagraph (C), the Corporation shall establish, for an insurance policy for each insurable crop that is planted in the spring, a sales closing date that is 30 days earlier than the corresponding sales closing date that was established for the 1994 crop year.

''(C) EXCEPTION.—If compliance with subparagraph (B) results in a sales closing date for an agricultural commodity that is earlier than January 31, the sales closing date for that commodity shall be January 31 beginning with the 2000 crop year.''.

SEC. 207. The Secretary of Agriculture may use not more than $1,090,000 of funds of the Commodity Credit Corporation to provide emergency assistance to producers on farms located in Harney County, Oregon, who suffered flood-related crop and forage losses in 1999 and several previous years and are expected to suffer continuing economic losses until the floodwaters recede. The amount made available under this section shall be available for such losses for such years as determined appropriate by the Secretary to compensate such producers for hay, grain, and pasture losses due to the floods and for related economic losses.

SEC. 208. TILLAMOOK RAILROAD DISASTER REPAIRS. In addition to amounts appropriated or otherwise made available for rural development programs of the United States Department of Agriculture by Public Law 106–78, there are appropriated $5,000,000 which may be made available to repair damage to the Tillamook Railroad caused by flooding and high winds (FEMA Disaster Number 1099–DR–OR) notwithstanding any other provision of law.

SEC. 209. At the end of section 746 of Public Law 106–78, insert the following before the period: '': Provided, That the Congressional Hunger Center may invest such funds and expend the income from such funds in a manner consistent with this section: Provided further, That notwithstanding any other provision of law, funds appropriated pursuant to this section may be paid directly to the Congressional Hunger Center.''.

SEC. 210. The Secretary of Agriculture may reprogram funds appropriated by Public Law 106–78 for the cost of rural electrification and telecommunications loans to provide up to $100,000 for the cost of guaranteed loans authorized by section 306 of the Rural Electrification Act of 1936.

SEC. 211. Section 755(b) of Public Law 106–78 is hereby repealed.

SEC. 212. Section 602(b)(2) of the Small Business Reauthorization Act of 1997 (15 U.S.C. 657a note) is amended—

(1) in subparagraph (I), by striking ''and'' at the end;

(2) in subparagraph (J), by striking the period at the end and inserting '';''; and

(3) by inserting at the end the following:

''(K) the Department of Commerce;

''(L) the Department of Justice; and

''(M) the Department of State.''.

SEC. 213. (a) REVISED SCHEDULE FOR COMPETITIVE BIDDING OF SPECTRUM.—(1) Section 337(b) of the Communications Act of 1934 (47 U.S.C. 337(b)) is amended by striking ''shall—'' and all that follows and inserting ''shall commence assignment of licenses for public safety services created pursuant to subsection (a) no later than September 30, 1998.''.

(2) Commencing on the date of the enactment of this Act, the Federal Communications Commission shall initiate the competitive bidding process previously required under section 337(b)(2) of the Communications Act of 1934 (as repealed by the amendment made by paragraph (1)).

(3) The Federal Communications Commission shall conduct the competitive bidding process described in paragraph (2) in a manner that ensures that all proceeds of such bidding are deposited in accordance with section 309(j)(8) of the Communications Act of 1934 (47 U.S.C. 309(j)(8)) not later than September 30, 2000.

(4)(A) To expedite the assignment by competitive bidding of the frequencies identified in section 337(a)(2) of the Communications Act of 1934 (47 U.S.C. 337(a)(2)), the rules governing such frequencies shall be effective immediately upon publication in the Federal Register without regard to sections 553(d), 801(a)(3), 804(2), and 806(a) of title 5, United States Code.

(B) Chapter 6 of title 5, United States Code, section 3 of the Small Business Act (15 U.S.C. 632), and sections 3507 and 3512 of title 44, United States Code, shall not apply to the rules and competitive bidding procedures governing the frequencies described in subparagraph (A).

(5) Notwithstanding section 309(b) of the Communications Act of 1934 (47 U.S.C. 309(b)), no application for an instrument of authorization for the frequencies described in paragraph (4) may be granted by the Federal Communications Commission earlier than 7 days following issuance of public notice by the Commission of the acceptance for filing of such application or of any substantial amendment thereto.

(6) Notwithstanding section 309(d)(1) of the Communications Act of 1934 (47 U.S.C. 309(d)(1)), the Federal Communications Commission may specify a period (which shall be not less than 5 days following issuance of the public notice described in paragraph (5)) for the filing of petitions to deny any application for an instrument of authorization for the frequencies described in paragraph (4).

(b) REPORTS.—(1) Not later than 30 days after the date of the enactment of this Act, the Director of the Office of Management and Budget and the Federal Communications Commission shall each submit to the appropriate congressional committees a report which shall—

(A) set forth the anticipated schedule (including specific dates) for—

(i) preparing and conducting the competitive bidding process required by subsection (a); and

(ii) depositing the receipts of the competitive bidding process;

(B) set forth each significant milestone in the rulemaking process with respect to the competitive bidding process; and

(C) include an explanation of the effect of each requirement in subsection (a) on the schedule for the competitive bidding process and any post-bidding activities (including the deposit of receipts) when compared with the schedule for the competitive bidding and any post-bidding activities (including the deposit of receipts) that would otherwise have occurred under section 337(b)(2) of the Communications Act of 1934 (47 U.S.C. 337(b)(2)) if not for the enactment of subsection (a).

(2) Not later than 60 days after the date of the enactment of this Act, the Federal Communications Commission shall submit to the appropriate congressional committees a report which shall set forth for each spectrum auction held by

the Commission since January 1, 1998, information on—

(A) the time required for each stage of preparation for the auction;

(B) the date of the commencement and of the completion of the auction;

(C) the time which elapsed between the date of the completion of the auction and the date of the first deposit of receipts from the auction in the Treasury; and

(D) the amounts, summarized by month, of all subsequent deposits in a Treasury receipt account from the auction.

(3) Not later than October 31, 2000, the Federal Communications Commission shall submit to the appropriate congressional committees a report which shall—

(A) describe the course of the competitive bidding process required by subsection (a) through September 30, 2000, including the amount of any receipts from the competitive bidding process deposited in the Treasury as of September 30, 2000; and

(B) if the course of the competitive bidding process has included any deviations from the schedule set forth under paragraph (1)(A), an explanation for such deviations from the schedule.

(4) Each report required by this subsection shall be prepared by the agency concerned without influence of any other Federal department or agency.

(5) In this subsection, the term ''appropriate congressional committees'' means the following:

(A) The Committees on Appropriations, the Budget, and Commerce, Science, and Transportation of the Senate.

(B) The Committees on Appropriations, the Budget, and Commerce of the House of Representatives.

(c) CONSTRUCTION.—Nothing in this section shall be construed to supersede the requirements placed on the Federal Communications Commission by section 337(d)(4) of the Communications Act of 1934 (47 U.S.C. 337(d)(4)).

(d) REPEAL OF SUPERSEDED PROVISIONS.—Section 8124 of the Department of Defense Appropriations Act, 2000 is repealed.

SEC. 214. (a) Section 8175 of the Department of Defense Appropriations Act, 2000 (Public Law 106–79) is amended by striking section 8175 and inserting the following new section 8175:

''SEC. 8175. Notwithstanding any other provision of law, the Department of Defense shall make progress payments based on progress no less than 12 days after receiving a valid billing and the Department of Defense shall make progress payments based on cost no less than 19 days after receiving a valid billing: Provided, That this provision shall be effective only with respect to billings received during the last month of the fiscal year.''.

(b) The amendment made by subsection (a) shall take effect as if included in the Department of Defense Appropriations Act, 2000 (Public Law 106–79), to which such amendment relates.

SEC. 215. (a) Section 8176 of the Department of Defense Appropriations Act, 2000 (Public Law 106–79) is amended by striking section 8176 and inserting the following new section 8176:

''SEC. 8176. Notwithstanding any other provision of law, the Department of Defense shall make adjustments in payment procedures and policies to ensure that payments are made no earlier than one day before the date on which the payments would otherwise be due under any other provision of law: Provided, That this provision shall be effective only with respect to invoices received during the last month of the fiscal year.''.

(b) The amendment made by subsection (a) shall take effect as if included in the Department of Defense Appropriations Act, 2000 (Public Law 106–79), to which such amendment relates.

SEC. 216. The Office of Net Assessment in the Office of the Secretary of Defense, jointly with the United States Pacific Command, shall submit, through the Under Secretary of Defense (Policy), a report to Congress no later than 270 days after the enactment of this Act which addresses the following issues: (1) A review of the operational planning and other preparations of the United States Department of Defense, including but not limited to the United States Pacific Command, to implement the relevant sections of the Taiwan Relations Act since its enactment in 1979; and (2) a review of evaluation of all gaps in relevant knowledge about the People's Republic of China's capabilities and intentions as they might affect the current and future military balance between Taiwan and the People's Republic of China, including both classified United States intelligence information and Chinese open source writing. The report shall be submitted in classified form, with an unclassified summary.

SEC. 217. The Secretary of Defense, jointly with the Secretary of Veterans Affairs, shall submit a report to Congress no later than 90 days after the enactment of this Act assessing the adequacy of medical research activities currently underway or planned to commence in fiscal year 2000 to investigate the health effects of low-level chemical exposures of Persian Gulf military forces while serving in the Southwest Asia theater of operations. This report shall also identify and assess valid proposals (including the cost of such proposals) to accelerate medical research in this area, especially those aimed at studying, diagnosing, and developing treatment protocols for Gulf War veterans with multi-system symptoms and multiple chemical intolerances.

(INCLUDING TRANSFER OF FUNDS)

SEC. 218. In addition to amounts appropriated or otherwise made available in Public Law 106–79, $100,000,000 is hereby appropriated to the Department of the Army and shall be made available only for transfer to titles II, III, IV, and V of Public law 106–79 to meet readiness needs: Provided, That these funds may be used to initiate the fielding and equipping, to include leasing of vehicles for test and evaluation, of two prototype brigade combat teams at Fort Lewis, Washington: Provided further, That funds transferred pursuant to this section shall be merged with and be available for the same purposes and for the same time period as the appropriation to which transferred: Provided further, That the transfer authority provided in this section is in addition to any transfer authority available to the Department of Defense: Provided further, That none of the funds made available under this section may be obligated or expended until 30 days after the Chief of Staff of the Army submits a detailed plan for the expenditure of the funds to the congressional defense committees.

(TRANSFER OF FUNDS)

SEC. 219. Of the funds appropriated in Public Law 106–79, $500,000 shall be transferred from ''Research, Development, Test, and Evaluation, Army'' to ''Operation and Maintenance, Defense-Wide'': Provided, That funds transferred pursuant to this section shall be merged with and be available for the same purposes and for the same time period as the appropriation to which transferred.

SEC. 220. EXEMPTION FOR WASTE MANAGEMENT FACILITIES OWNED OR OPERATED BY THE UNITED STATES. No form of financial responsibility requirement shall be imposed on the Federal Government or its contractors as to the operation of any waste management facility which is designed to manage transuranic waste material and is owned or operated by a department, agency, or instrumentality of the executive branch of the Federal Government and subject to regulation by the Solid Waste Disposal Act (42 U.S.C. 6901 et seq.) or by a State program authorized under that Act.

SEC. 221. (a) That portion of the project for navigation, Newport Harbor, Rhode Island, authorized by the Rivers and Harbors Act of 1907, House Document 438, 59th Congress, 2nd Session, described by the following: N148,697.62, E548,281.70, thence running south 9 degrees 42 minutes 14 seconds east 720.92 feet to a point N147,987.01, E548,403.21, thence running south 80 degrees 17 minutes 45.2 seconds west 313.60 feet to a point N147,934.15, E548,094.10, thence running north 8 degrees 4 minutes 50 seconds west 776.9 feet to a point N148,703.30, E547,984.90, thence running south 88 degrees 54 minutes 13 seconds east 296.85 feet returning to a point N148,697.62, E548,281.70 shall no longer be authorized after the date of enactment of this Act.

(b) The area described by the following: N150,482.96, E548,057.84, thence running south 6 degrees 9 minutes 49 seconds east 1300 feet to a point N149,190.47, E548,197.42, thence running south 9 degrees 42 minutes 14 seconds east 500 feet to a point N148,697.62, E548,281.70, thence running north 88 degrees 54 minutes 13 seconds west 377.89 feet to a point N148,704.85, E547,903.88, thence running north 8 degrees 4 minutes 52 seconds west 1571.83 feet to a point N150,261.08, E547,682.92, thence running north 59 degrees 22 minutes 58 seconds east 435.66 feet returning to a point N150,482.96, E548,057.84 shall be redesignated as an anchorage area.

(c) The area described by the following: N147,427.22, E548,464.05, thence running south 2 degrees 10 minutes 32 seconds east 273.7 feet to a point N147,153.72, E548,474.44, thence running south 5 degrees 18 minutes 48 seconds west 2375.34 feet to a point N144,788.59, E548,254.48, thence running south 73 degrees 11 minutes 48 seconds west 93.40 feet to a point N144,761.59, E548,165.07, thence running north 2 degrees 10 minutes 39 seconds west 2589.81 feet to a point N147,349.53, E548,066.67, thence running north 78 degrees 56 minutes 16 seconds east 404.9 feet returning to a point N147,427.22, E548,464.05 shall be redesignated as an anchorage area.

SEC. 222. There is hereby appropriated to the Department of the Interior $1,250,000 for the acquisition of lands in the Wertheim National Wildlife Refuge, to be derived from the Land and Water Conservation Fund.

SEC. 223. For a payment to Virginia C. Chafee, widow of John H. Chafee, late a Senator from Rhode Island, $136,700.

SEC. 224. Paragraph (5) of section 201(a) of the Congressional Budget Act of 1974 (2 U.S.C. 601(a)) is amended to read as follows:

''(5)(A) The Director shall receive compensation at an annual rate of pay that is equal to the lower of—

''(i) the highest annual rate of compensation of any officer of the Senate; or

''(ii) the highest annual rate of compensation of any officer of the House of Representatives.

''(B) The Deputy Director shall receive compensation at an annual rate of pay that is $1,000 less than the annual rate of pay received by the Director, as determined under subparagraph (A).''.

SEC. 225. In addition to amounts otherwise made available in Public Law 106–69 (Department of Transportation and Related Agencies Appropriations Act, 2000) to carry out 49 United States Code, 5309(m)(1)(C), $1,750,000 is made available from the Mass Transit Account of the Highway Trust Fund for Twin Cities, Minnesota metropolitan buses and bus facilities; $750,000 is made available from the Mass Transit Account of the Highway Trust Fund for Santa Clarita, California bus maintenance facility; $1,000,000 is made available from the Mass Transit Account of the Highway Trust Fund for a Lincoln, Nebraska bus maintenance facility; and $2,500,000 is made available from the Mass Transit Account of the Highway Trust Fund for Anchorage, Alaska 2001 Special Olympics Winter Games buses and bus facilities: Provided, That notwithstanding any other provision of law, $2,000,000 of the funds available in fiscal year 2000 under section 1101(a)(9) of Public Law 105–178, as amended, for the National corridor

planning and development and coordinated border infrastructure programs shall be made available for the planning and design of a highway corridor between Dothan, Alabama and Panama City, Florida: Provided further, That under ''Capital Investment Grants'' in Public Law 106–69, item number 66 shall be amended by striking ''Colorado Association of Transit Agencies'' and inserting ''Colorado buses and bus facilities'', item number 107 shall be amended by striking ''Kansas Public Transit Association buses and bus facilities'' and inserting ''Kansas buses and bus facilities'', the figure in item number 92 shall be amended to read ''3,340,000'', item number 251 shall be amended by inserting after ''buses'' the following: ''and bus facilities'', and there shall be inserted after item number 279 under ''Capital Investment Grants'' the following:

''280. Iowa ... Mason City, bus facility 160,000'':

Provided further, That Public Law 105–277, 112 Stat. 2681–458, item number 243 shall be amended by inserting after the word ''buses'' the following: ''and bus facilities''.

SEC. 226. No funds made available in Public Law 106–69 or any other Act shall be used to decommission or otherwise reduce operations of U.S. Coast Guard WYTL harbor tug boats.

SEC. 227. Section 351 of Public Law 106–69 is amended by striking ''provided'' and inserting ''appropriated or limited''.

SEC. 228. For purposes of section 5117(b)(5) of the Transportation Equity Act for the 21st Century, for fiscal years 1998, 1999 and 2000 the cost-sharing provision of section 5001(b) shall not apply.

SEC. 229. Section 366 of the Department of Transportation and Related Agencies Appropriations Act, 2000 (Public Law 106–69) is amended—

(1) by striking ''and subject to subsection (b),''; and

(2) by striking ''under subsection (a)'' and inserting ''under this section''.

SEC. 230. Section 408 of the Woodrow Wilson Memorial Bridge Authority Act of 1995 (109 Stat. 631) is amended—

(1) by striking ''The'' and inserting ''(a) IN GENERAL.—The''; and

(2) by adding at the end the following:

''(b) TRANSPORTATION IMPROVEMENT PROGRAM.—Notwithstanding sections 134(g)(2)(B), 134(h)(3)(D) and 135(f)(2)(D) of title 23, United States Code, the Project may be included in a metropolitan long-range transportation plan, a metropolitan transportation improvement program, and a State transportation improvement program under sections 134 and 135, respectively, of that title.''.

SEC. 231. (a) EXEMPTION FOR AIRCRAFT MODIFICATION OR DISPOSAL, SCHEDULED HEAVY MAINTENANCE, OR LEASING-RELATED FLIGHTS.—Section 47528 is amended—

(1) by striking ''subsection (b)'' in subsection (a) and inserting ''subsection (b) or (f)'';

(2) by adding at the end of subsection (e) the following:

''(4) An air carrier operating Stage 2 aircraft under this subsection may transport Stage 2 aircraft to or from the 48 contiguous States on a non-revenue basis in order—

''(A) to perform maintenance (including major alterations) or preventative maintenance on aircraft operated, or to be operated, within the limitations of paragraph (2)(B); or

''(B) conduct operations within the limitations of paragraph (2)(B).''; and

(3) adding at the end thereof the following:

''(f) AIRCRAFT MODIFICATION, DISPOSAL, SCHEDULED HEAVY MAINTENANCE, OR LEASING.—

''(1) IN GENERAL.—The Secretary shall permit a person to operate after December 31, 1999, a Stage 2 aircraft in nonrevenue service through the airspace of the United States or to or from an airport in the contiguous 48 States in order to—

''(A) sell, lease, or use the aircraft outside the contiguous 48 States;

''(B) scrap the aircraft;

''(C) obtain modifications to the aircraft to meet Stage 3 noise levels;

''(D) perform scheduled heavy maintenance or significant modifications on the aircraft at a maintenance facility located in the contiguous 48 States;

''(E) deliver the aircraft to an operator leasing the aircraft from the owner or return the aircraft to the lessor;

''(F) prepare or park or store the aircraft in anticipation of any of the activities described in subparagraphs (A) through (E); or

''(G) divert the aircraft to an alternative airport in the contiguous 48 States on account of weather, mechanical, fuel, air traffic control, or other safety reasons while conducting a flight in order to perform any of the activities described in subparagraphs (A) through (F).

''(2) PROCEDURE TO BE PUBLISHED.—The Secretary shall establish and publish, not later than 30 days after the date of enactment of this Act a procedure to implement paragraph (1) of this subsection through the use of categorical waivers, ferry permits, or other means.''.

(b) NOISE STANDARDS FOR EXPERIMENTAL AIRCRAFT.—

(1) IN GENERAL.—Section 47528(a) of title 49 is amended by inserting ''(for which an airworthiness certificate other than an experimental certificate has been issued by the Administrator)'' after ''civil subsonic turbojet''.

(2) FAR MODIFIED.—The Federal Aviation Regulations, contained in Part 14 of the Code of Federal Regulations, that implement section 47528 and related provisions shall be deemed to incorporate this change on the effective date of this Act.

(3) OTHER.—Notwithstanding any other provision of law, none of the funds in this or any other Act may be used to implement or otherwise enforce Stage 3 noise limitations in title 49 United States Code, section 47528(a) for aircraft operating under an experimental airworthiness certification issued by the Department of Transportation.

SEC. 232. In addition to amounts provided to the Federal Railroad Administration in Public Law 106–69, for necessary expenses for engineering, design and construction activities to enable the James A. Farley Post Office in New York City to be used as a train station and commercial center, to become available on October 1 of the fiscal year specified and to remain available until expended: fiscal year 2001, $20,000,000; fiscal year 2002, $20,000,000; fiscal year 2003, $20,000,000.

SEC. 233. (a) Section 203(p)(1)(B)(ii) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 484(p)(1)(B)(ii)) is amended by striking ''December 31, 1999.'' and inserting ''July 31, 2000.''.

(b) During the period beginning January 1, 2000, and ending July 31, 2000, the Administrator may convey any property for which an application for the transfer of property is under consideration and pending on the date of the enactment of this Act.

SEC. 234. Effective on November 15, 1999, or the last day of the 1st session of the 106th Congress, whichever is later, in addition to amounts otherwise provided to address the expenses of Year 2000 conversion of Federal information technology systems, not to exceed 10 percent of any appropriation for salaries and expenses made available to an agency for fiscal year 2000 in this or any other Act may be used by the agency for implementation of agency business continuity and contingency plans in furtherance of Year 2000 compliance by Federal agencies: Provided, That such amounts may be transferred between agency accounts: Provided further, That the transfer authority provided in this section is in addition to any other transfer authority provided in this or any other Act: Provided further, That notice of any transfer under this section shall be transmitted to House and Senate Committees on Appropriations, the Senate Special Committee on the Year 2000 Technology Problem, the House Committee on Science, and the House Committee on Government Reform 10 days in advance of such transfer: Provided further, That, under circumstances reasonably requiring immediate action, such notice shall be transmitted as soon as possible but in no case more than 5 days after such transfer: Provided further, That the authority granted in this section shall expire on February 29, 2000.

SEC. 235. Title III of Public Law 106–58, under the heading ''Office of Administration, Salaries and Expenses'', is amended by inserting after ''infrastructure'' the following: '': Provided, That the funds for the capital investment plan shall remain available until September 30, 2001''.

SEC. 236. POSTPONEMENT OF DATE OF TERMINATION OF FEDERAL AGENCY REPORTING REQUIREMENTS. Section 3003(a)(1) of the Federal Reports Elimination and Sunset Act of 1995 (31 U.S.C. 1113 note) is amended by striking ''4 years after the date of the enactment of this Act'' and inserting ''May 15, 2000''.

SEC. 237. In addition to amounts appropriated to the Office of National Drug Control Policy, $3,000,000 is appropriated: Provided, That this amount shall be made available by grant to the United States Olympic Committee for its anti-doping program within 30 days of the enactment of this Act.

SEC. 238. (a) IN GENERAL.—(1) Section 5315 of title 5, United States Code, is amended by striking the following item: ''Commissioner of Customs, Department of the Treasury''.

(2) Section 5314 of title 5, United States Code, is amended by inserting at the end the following item: ''Commissioner of Customs, Department of the Treasury''.

(b) EFFECTIVE DATE.—The amendment made by this subsection shall take effect on January 1, 2000.

SEC. 239. (a) Section 101(d)(3) of title I of Division C of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Public Law 105–277, 112 Stat. 2681–584–2681–585) is amended by inserting ''not'' after ''the Inspector General Act of 1978 (5 U.S.C. App.) shall''.

(b) The amendment made by subsection (a) shall be effective as if included in the enactment of section 101 of title I of division C of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999.

SEC. 240. For necessary expenses of the United States Secret Service, an additional $10,000,000 is appropriated for ''Salaries and Expenses''. In addition, for the purposes of meeting additional requirements of the United States Secret Service for fiscal year 2000, the Secretary of the Treasury is authorized and directed to transfer $21,000,000 to the United States Secret Service out of all the funds available to the Department of the Treasury no later than 120 days after enactment of this Act: Provided, That the transfer authority provided in this section is in addition to any other transfer authority contained elsewhere in this or any other Act: Provided further, That such transfers pursuant to this section be taken from programs, projects, and activities as determined by the Secretary of the Treasury and subject to the advance approval of the Committee on Appropriations.

SEC. 241. Section 404(b) of the Government Management Reform Act of 1994 (31 U.S.C. 501 note) is amended by striking: ''December 31, 1999'' and inserting ''April 30, 2000''.

SEC. 242. (a) The seventh paragraph under the heading ''Community Development Block

Grants'' in title II of H.R. 2684 (Public Law 106–74) is amended by striking the figure making individual grants for targeted economic investments and inserting ''$250,175,000'' in lieu thereof.

(b) The statement of the managers of the committee of conference accompanying H.R. 2684 (Public Law 106–74; House Report No. 106–379) is deemed to be amended under the heading ''Community Development Block Grants'' to include in the description of targeted economic development initiatives the following:

''—$500,000 to Saint John's County, Florida for water, wastewater, and sewer system improvements;

''—$1,000,000 to the City of San Dimas, California for structural improvements, earthquake reinforcement, and compliance with the Americans with Disabilities Act, to the Walker House;

''—$2,000,000 to the City of Youngstown in Youngstown, Ohio for site acquisition, planning, architectural design, and preliminary construction activities of a convocation/community center;

''—$875,000 to Chippewa County, Wisconsin for development of the Lake Wissota Business Park;

''—$1,500,000 to Lake Marion Regional Water Agency in South Carolina, for continued development of water supply needs;

''—$650,000 to Santa Fe County, New Mexico, for the Santa Fe Regional Water Management and River Restoration Strategy (including activities of partner governments and agencies);

''—$650,000 to the Dunbar Community Center in Springfield, Massachusetts to expand its facilities''.

TITLE III—FISCAL YEAR 2000 OFFSETS AND RESCISSIONS

SEC. 301. (a) GOVERNMENT-WIDE RESCISSIONS.—There is hereby rescinded an amount equal to 0.38 percent of the discretionary budget authority provided (or obligation limit imposed) for fiscal year 2000 in this or any other Act for each department, agency, instrumentality, or entity of the Federal Government.

(b) RESTRICTIONS.—In carrying out the rescissions made by subsection (a),—

(1) no program, project, or activity of any department, agency, instrumentality, or entity may be reduced by more than 15 percent (with ''programs, projects, and activities'' as delineated in the appropriations Act or accompanying report for the relevant account, or for accounts and items not included in appropriations Acts, as delineated in the most recently submitted President's budget),

(2) no reduction shall be taken from any military personnel account, and

(3) the reduction for the Department of Defense and Department of Energy Defense Activities shall be applied proportionately to all Defense accounts.

(c) REPORT.—The Director of the Office of Management and Budget shall include in the President's budget submitted for fiscal year 2001 a report specifying the reductions made to each account pursuant to this section.

SEC. 302. Section 7 of the Federal Reserve Act (12 U.S.C. 289) is amended as follows:

(1) by striking subsection (a)(3); and

(2) by inserting the following new subsection (b):

''(b) TRANSFER FOR FISCAL YEAR 2000.—

''(1) IN GENERAL.—The Federal reserve banks shall transfer from the surplus funds of such banks to the Board of Governors of the Federal Reserve System for transfer to the Secretary of the Treasury for deposit in the general fund of the Treasury, a total amount of $3,752,000,000 in fiscal year 2000.

''(2) ALLOCATED BY FED.—Of the total amount required to be paid by the Federal reserve banks under paragraph (1) for fiscal year 2000, the Board shall determine the amount each such bank shall pay in such fiscal year.

''(3) REPLENISHMENT OF SURPLUS FUND PROHIBITED.—During fiscal year 2000, no Federal reserve bank may replenish such bank's surplus fund by the amount of any transfer by such bank under paragraph (1).''.

SEC. 303. (a) Section 453(j) of the Social Security Act (42 U.S.C. 653(j)) is amended by adding at the end the following:

''(6) INFORMATION COMPARISONS AND DISCLOSURE FOR ENFORCEMENT OF OBLIGATIONS ON HIGHER EDUCATION ACT LOANS AND GRANTS.—

''(A) FURNISHING OF INFORMATION BY THE SECRETARY OF EDUCATION.—The Secretary of Education shall furnish to the Secretary, on a quarterly basis or at such less frequent intervals as may be determined by the Secretary of Education, information in the custody of the Secretary of Education for comparison with information in the National Directory of New Hires, in order to obtain the information in such directory with respect to individuals who—

''(i) are borrowers of loans made under title IV of the Higher Education Act of 1965 that are in default; or

''(ii) owe an obligation to refund an overpayment of a grant awarded under such title.

''(B) REQUIREMENT TO SEEK MINIMUM INFORMATION NECESSARY.—The Secretary of Education shall seek information pursuant to this section only to the extent essential to improving collection of the debt described in subparagraph (A).

''(C) DUTIES OF THE SECRETARY.—

''(i) INFORMATION COMPARISON; DISCLOSURE TO THE SECRETARY OF EDUCATION.—The Secretary, in cooperation with the Secretary of Education, shall compare information in the National Directory of New Hires with information in the custody of the Secretary of Education, and disclose information in that Directory to the Secretary of Education, in accordance with this paragraph, for the purposes specified in this paragraph.

''(ii) CONDITION ON DISCLOSURE.—The Secretary shall make disclosures in accordance with clause (i) only to the extent that the Secretary determines that such disclosures do not interfere with the effective operation of the program under this part. Support collection under section 466(b) shall be given priority over collection of any defaulted student loan or grant overpayment against the same income.

''(D) USE OF INFORMATION BY THE SECRETARY OF EDUCATION.—The Secretary of Education may use information resulting from a data match pursuant to this paragraph only—

''(i) for the purpose of collection of the debt described in subparagraph (A) owed by an individual whose annualized wage level (determined by taking into consideration information from the National Directory of New Hires) exceeds $16,000; and

''(ii) after removal of personal identifiers, to conduct analyses of student loan defaults.

''(E) DISCLOSURE OF INFORMATION BY THE SECRETARY OF EDUCATION.—

''(i) DISCLOSURES PERMITTED.—The Secretary of Education may disclose information resulting from a data match pursuant to this paragraph only to—

''(I) a guaranty agency holding a loan made under part B of title IV of the Higher Education Act of 1965 on which the individual is obligated;

''(II) a contractor or agent of the guaranty agency described in subclause (I);

''(III) a contractor or agent of the Secretary; and

''(IV) the Attorney General.

''(ii) PURPOSE OF DISCLOSURE.—The Secretary of Education may make a disclosure under clause (i) only for the purpose of collection of the debts owed on defaulted student loans, or overpayments of grants, made under title IV of the Higher Education Act of 1965.

''(iii) RESTRICTION ON REDISCLOSURE.—An entity to which information is disclosed under clause (i) may use or disclose such information only as needed for the purpose of collecting on defaulted student loans, or overpayments of grants, made under title IV of the Higher Education Act of 1965.

''(F) REIMBURSEMENT OF HHS COSTS.—The Secretary of Education shall reimburse the Secretary, in accordance with subsection (k)(3), for the additional costs incurred by the Secretary in furnishing the information requested under this subparagraph.''.

(b) PENALTIES FOR MISUSE OF INFORMATION.—Section 402(a) of the Child Support Performance and Incentive Act of 1998 (112 Stat. 669) is amended in the matter added by paragraph (2) by inserting ''or any other person'' after ''officer or employee of the United States''.

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective October 1, 1999.

SEC. 304. Section 110 of title 23, United States Code, is amended by adding at the end the following:

''(e) After making any calculation necessary to implement this section for fiscal year 2001, the amount available under paragraph (a)(1) shall be increased by $128,752,000. The amounts added under this subsection shall not apply to any calculation in any other fiscal year.

''(f) For fiscal year 2001, prior to making any distribution under this section, $22,029,000 of the allocation under paragraph (a)(1) shall be available only for each program authorized under chapter 53 of title 49, United States Code, and title III of Public Law 105–178, in proportion to each such program's share of the total authorization in section 5338 (other than 5338(h)) of such title and sections 3037 and 3038 of such Public Law, under the terms and conditions of chapter 53 of such title.

''(g) For fiscal year 2001, prior to making any distribution under this section, $399,000 of the allocation under paragraph (a)(1) shall be available only for motor carrier safety programs under sections 31104 and 31107 of title 49, United States Code; $274,000 for NHTSA operations and research under section 403 of title 23, United States Code; and $787,000 for NHTSA highway traffic safety grants under chapter 4 of title 23, United States Code.''.

SEC. 305. Notwithstanding section 3324 of title 31, United States Code, and section 1006(h) of title 37, United States Code, the basic pay and allowances that accrues to members of the Army, Navy, Marine Corps, and Air Force for the pay period ending on September 30, 2000, shall be paid, whether by electronic transfer of funds or otherwise, no earlier than October 1, 2000.

SEC. 306. The pay of any Federal officer or employee that would be payable on September 29, 2000, or September 30, 2000, for the preceding applicable pay period (if not for this section) shall be paid, whether by electronic transfer of funds or otherwise, on October 1, 2000.

SEC. 307. Under the terms of section 251(b)(2) of Public Law 99–177, an adjustment for rounding shall be provided for the first amount referred to in section 251(c)(4)(A) of such Act equal to 0.2 percent of such amount.

TITLE IV—CANYON FERRY RESERVOIR, MONTANA

SEC. 401. DEFINITION OF INDIVIDUAL PROPERTY PURCHASER.

Section 1003 of title X of division C of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (112 Stat. 2681–711) is amended—

(1) by redesignating paragraphs (4) through (12) as paragraphs (5) through (13), respectively; and

(2) by inserting after paragraph (3) the following:

''(4) INDIVIDUAL PROPERTY PURCHASER.—The term 'individual property purchaser', with respect to an individual cabin site described in section 1004(b), means a person (including CFRA or a lessee) that purchases that cabin site.

SEC. 402. SALE OF PROPERTIES.

Section 1004 of title X of division C of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999, is amended—

(1) in subsection (c)(2) (112 Stat. 2681–713), by striking subparagraph (B) and inserting the following:

''(B) APPRAISAL.—

''(i) IN GENERAL.—The appraisal under subparagraph (A) shall be based on the Canyon Ferry Cabin Site appraisal with a completion date of March 29, 1999, and amended June 11, 1999, with an effective date of valuation of October 15, 1998, for the Bureau of Reclamation, on the conditions stated in this subparagraph.

''(ii) MODIFICATIONS.—The contract appraisers that conducted the original appraisal having an effective date of valuation of October 15, 1998, for the Bureau of Reclamation shall make appropriate modifications to permit recalculation of the lot values established in the original appraisal into an updated appraisal, the function of which shall be to provide market values for the sale of each of the 265 Canyon Ferry Cabin site lots.

''(iii) CHANGES IN PROPERTY CHARACTERISTICS.—If there are any changes in the characteristic of a property that form part of the basis of the updated appraisal (including a change in size, easement considerations, or updated analyses of the physical characteristics of a lot), the contract appraisers shall make an appropriate adjustment to the updated appraisal.

''(iv) UPDATING.—Subject to the approval of CFRA and the Secretary, the fair market values established by the appraisers under this paragraph may be further updated periodically by the contract appraisers through appropriate market analyses.

''(v) RECONSIDERATION.—The Bureau of Reclamation and the 265 Canyon Ferry cabin owners have the right to seek reconsideration, before commencement of the updated appraisal, of the assumptions that the appraisers used in arriving at the fair market values derived in the original appraisal.

''(vi) CONTINUING VALIDITY.—Notwithstanding any other provision of law, the October 15, 1998, Canyon Ferry Cabin Site original appraisal, as provided for in this paragraph, shall remain valid for use by the Bureau of Reclamation in the sale process for a period of not less than 3 years from the date of completion of the updated appraisal.'';

(2) in subsection (d) (112 Stat. 2681–713)—

(A) in paragraph (1)(D), by adding at the end the following:

''(iii) REMAINING LEASES.—

''(I) CONTINUATION OF LEASES.—The remaining lessees shall have a right to continue leasing through August 31, 2014.

''(II) RIGHT TO CLOSE.—The remaining leases shall have the right to close under the terms of the sale at any time before August 31, 2014. On termination of the lease either by expiration under the terms of the lease or by violation of the terms of the lease, all personal property and improvements will be removed, and the cabin site shall remain in Federal ownership.''; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by inserting ''or if no one (including CFRA) bids,'' after ''bid''; and

(ii) in subparagraph (D)—

(I) by striking ''12 months'' and inserting ''36 months''; and

(II) by adding at the end the following: ''If the requirement of the preceding sentence is not met, CFRA may close on all remaining cabin sites or up to the 75 percent requirement. If CFRA does not exercise either such option, the Secretary shall conduct another sale for the remaining cabin sites to close immediately, with proceeds distributed in accordance with section 1008.'';

(3) by striking subsection (e) (112 Stat. 2681–714) and inserting the following:

''(e) ADMINISTRATIVE COSTS.—

''(1) ALLOCATION OF FUNDING.—The Secretary shall allocate all funding necessary to conduct the sales process for the sale of property under this title.

''(2) REIMBURSEMENT.—Any reasonable administrative costs incurred by the Secretary (including the costs of survey and appraisals incident to the conveyance under subsection (a)) shall be proportionately reimbursed by the property owner a the time of closing.''; and

(4) by striking subsection (f) (112 Stat. 2681–714) and inserting the following:

''(f) TIMING.—The Secretary shall—

''(1) immediately begin preparing for the sales process on enactment of this Act; and

''(2) not later than 1 year after the date of enactment of this Act, begin conveying the property described in subsection (b).''.

SEC. 403. MONTANA FISH AND WILDLIFE CONSERVATION TRUST.

Section 1007(b) of title X of division C of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (112 Stat. 2681–715), is amended—

(1) in subsection (c)—

(A) in paragraph (1), in the matter preceding subparagraph (A), by striking ''trust manager'' and inserting ''trust manager (referred to in this section as the 'trust manager')'';

(B) in paragraph (2)(A), in the matter preceding clause (i), by striking ''agency Board'' and inserting ''Agency Board (referred to in this section as the 'Joint State-Federal Agency Board')''; and

(C) in paragraph (3)(A), by striking ''Advisory Board'' and inserting ''Advisory Board (referred to in this section as the 'Citizen Advisory Board')''; and

(2) by adding at the end the following:

''(f) RECREATION TRUST AGREEMENT.—

''(1) IN GENERAL.—The Trust, acting through the trust manager, in consultation with the Joint State-Federal Agency Board and the Citizen Advisory Board, shall enter into a legally enforceable agreement with CFRA (referred to in this section as the 'Recreation Trust Agreement').

''(2) CONTENTS.—The Recreation Trust Agreement shall provide that—

''(A) on receipt of proceeds of the sale of a property under section 1004, the Trust shall loan up to $3,000,000 of the proceeds to CFRA;

''(B) CFRA shall deposit all funds borrowed under subparagraph (A) in the Canyon Ferry-Broadwater County Trust;

''(C) CFRA and the individual purchasers shall repay the principal of the loan to the Trust as soon as reasonably practicable in accordance with a repayment schedule specified in the loan agreement; and

''(D) until such time as the principal is repaid in full, CFRA and the individual purchasers shall make an annual interest payment on the outstanding principal of the loan to the Trust at an interest rate determined in accordance with paragraph (4)(C).

''(3) TREATMENT OF INTEREST PAYMENTS.—All interest payments received by the Trust under paragraph (2)(D) shall be treated as earnings under subsection (d)(2).

''(4) FIDUCIARY RESPONSIBILITY.—In negotiating the Recreation Trust Agreement, the trust manager shall act in the best interests of the Trust to ensure—

''(A) the security of the loan;

''(B) timely repayment of the principal; and

''(C) payment of a fair interest rate, of not less than 6 nor more than 8 percent per year, based on the length of the term of a loan that is comparable to the term of a traditional home mortgage.

''(g) RESTRICTION ON DISBURSEMENT.—Except as provided in subsection (f), the trust manager shall not disburse any funds from the Trust until August 1, 2001, as provided for in the Recreation Trust Agreement, unless Broadwater County, at an earlier date, certifies that the Canyon Ferry-Broadwater County Trust has been fully funded in accordance with this title.

''(h) CONDITION TO SALE.—No closing of property under section 1004 shall be made until the Recreation Trust Agreement is entered into under subsection (f)''.

SEC. 404. CANYON FERRY-BROADWATER COUNTY TRUST.

Section 1008(b) of title X of division C of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (112 Stat. 2681–718), is amended—

(1) by striking paragraph (1) and inserting the following:

''(1) AGREEMENT.—

''(A) CONDITION TO SALE.—No closing of property under section 1004 shall be made until CFRA and Broadwater County enter into a legally enforceable agreement (referred to in this paragraph as the ' Contributions Agreement') concerning contributions to the Trust.

''(B) CONTENTS.—The Contributions Agreement shall require that on or before August 1, 2001, CFRA shall ensure that $3,000,000 in value is deposited in the Canyon Ferry-Broadwater County Trust from 1 or more of the following sources:

''(i) Direct contributions made by the purchasers on the sale of each cabin site.

''(ii) Annual contributions made by the purchasers.

''(iii) All other monetary contributions.

''(iv) In-kind contributions, subject to the approval of the County.

''(v) All funds borrowed by CFRA under section 1007(f).

''(vi) Assessments made against the cabin sites made under a county park district or any similar form of local government under the laws of the State of Montana.

''(vii) Any other contribution, subject to the approval of the County.'';

(2) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively;

(3) by inserting after paragraph (1) the following:

''(2) ALTERNATIVE FUNDING SOURCE.—If CFRA agrees to form a county park district under section 7–16–2401 et seq., of the Montana Code Annotated, or any other similar form of local government under the laws of the State of Montana, for the purpose of providing funding for the Trust pursuant to the Contributions Agreement, CFRA and Broadwater County may amend the Contributions Agreement as appropriate, so long as the monetary obligations of individual property purchases under the Contributions Agreement as amended are substantially similar to those specified in paragraph (1).''; and

(4) in paragraph (4) (as redesignated by paragraph (2), by striking ''until the condition stated in paragraph (1) is met''.

SEC. 405. TECHNICAL CORRECTIONS.

Title X of division C of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 is amended—

(1) in section 1001 (112 Stat. 2681–710), by striking ''section 4(b)'' and inserting ''section 1004(b)'';

(2) in section 1003 (112 Stat. 2681–711)—

(A) in paragraph (1), by striking ''section 8'' and inserting ''section 1008'';

(B) in paragraph (6), by striking ''section 7'' and inserting ''section 1007'';

(C) in paragraph (8)—

(i) in subparagraph (A), by striking ''section 4(b)'' and inserting ''1004(b)''; and

(ii) in subparagraph (B), by striking ''section 4(b)(1)(B)'' and inserting ''section 1004(b)(1)(B)''; and

(D) in paragraph (9), by striking ''section 4'' and inserting ''section 104''; and

(3) in section 1004 (112 Stat. 2681–712)—

(A) in subsection (b)(3)(B)(ii)(II), by striking ''section 4(a)'' and inserting ''section 1004(a)''; and

(B) in subsection (d)(2)(G), by striking ''section 6'' and inserting ''section 1006''.

TITLE V—INTERNATIONAL DEBT RELIEF

SEC. 501. ACTIONS TO PROVIDE BILATERAL DEBT RELIEF.

(a) CANCELLATION OF DEBT.—Subject to the availability of amounts provided in advance in

appropriations Acts, the President shall cancel all amounts owed to the United States (or any agency of the United States) by any country eligible for debt reduction under this section, as a result of loans made or credits extended prior to June 20, 1999, under any of the provisions of law specified in subsection (b).

(b) PROVISIONS OF LAW.—The provisions of law referred to in subsection (a) are the following:

(1) Sections 221 and 222 of the Foreign Assistance Act.

(2) The Arms Export Control Act (22 U.S.C. 2751 et seq.).

(3) Section 5(f) of the Commodity Credit Corporation Charter Act, section 201 of the Agricultural Trade Act of 1978 (7 U.S.C. 5621), or section 202 of such Act (7 U.S.C. 5622), or predecessor provisions under the Food for Peace Act of 1966.

(4) Title I of the Agricultural Trade Development and Assistance Act of 1954 (7 U.S.C. 1701 et seq.).

(c) OTHER DEBT REDUCTION AUTHORITIES.—The authority provided in this section is in addition to any other debt relief authority and does not in any way limit such authority.

(d) ELIGIBLE COUNTRIES.—A country that is performing satisfactorily under an economic reform program shall be eligible for cancellation of debt under this section if—

(1) the country, as of December 31, 2000, is eligible to borrow from the International Development Association;

(2) the country, as of December 31, 2000, is not eligible to borrow from the International Bank for Reconstruction and Development; and

(3)(A) the country has outstanding public and publicly guaranteed debt, the net present value of which on December 31, 1996, was at least 150 percent of the average annual value of the exports of the country for the period 1994 through 1996; or

(B)(i) the country has outstanding public and publicly guaranteed debt, the net present value of which, as of the date the President determines that the country is eligible for debt relief under this section, is at least 150 percent of the annual value of the exports of the country; or

(ii) the country has outstanding public and publicly guaranteed debt, the net present value of which, as of the date the President determines that the country is eligible for debt relief under this section, is at least 250 percent of the annual fiscal revenues of the country, and has minimum ratios of exports to Gross Domestic Product of 30 percent, and of fiscal revenues to Gross Domestic Product of 15 percent.

(e) PRIORITY.—In carrying out subsection (a), the President should seek to leverage scarce foreign assistance and give priority to heavily indebted poor countries with demonstrated need and the capacity to use such relief effectively.

(f) EXCEPTIONS.—A country shall not be eligible for cancellation of debt under this section if the government of the country—

(1) has an excessive level of military expenditures;

(2) has repeatedly provided support for acts of international terrorism, as determined by the Secretary of State under section 6(j)(1) of the Export Administration Act of 1979 (50 U.S.C. App. 2405(j)(1)) or section 620A(a) of the Foreign Assistance Act of 1961 (22 U.S.C. 2371(a));

(3) is failing to cooperate on international narcotics control matters; or

(4) (including its military or other security forces), engages in a consistent pattern of gross violations of internationally recognized human rights.

(g) ADDITIONAL REQUIREMENT.—A country which is otherwise eligible to receive cancellation of debt under this section may receive such cancellation only if the country has committed, in connection with a social and economic reform program—

(1) to enable, facilitate, or encourage the implementation of policy changes and institutional reforms under economic reform programs, in a manner that ensures that such policy changes and institutional reforms are designed and adopted through transparent and participatory processes;

(2) to adopt an integrated development strategy of the type described in section 1624(a) of the International Financial Institutions Act, to support poverty reduction through economic growth, that includes monitorable poverty reduction goals;

(3) to take steps so that the financial benefits of debt relief are applied to programs to combat poverty (in particular through concrete measures to improve economic infrastructure, basic services in education, nutrition, and health, particularly treatment and prevention of the leading causes of mortality) and to redress environmental degradation;

(4) to take steps to strengthen and expand the private sector, encourage increased trade and investment, support the development of free markets, and promote broad-scale economic growth;

(5) to implement transparent policy making and budget procedures, good governance, and effective anticorruption measures;

(6) to broaden public participation and popular understanding of the principles and goals of poverty reduction, particularly through economic growth, and good governance; and

(7) to promote the participation of citizens and nongovernmental organizations in the economic policy choices of the government.

(h) CERTAIN PROHIBITIONS INAPPLICABLE.—Except as the President may otherwise determine for reasons of national security, a cancellation of debt under this section shall not be considered to be assistance for purposes of any provision of law limiting assistance to a country. The authority to provide for cancellation of debt under this section may be exercised notwithstanding section 620(r) of the Foreign Assistance Act of 1961, or any similar provision of law.

(i) AUTHORIZATION OF APPROPRIATIONS.—For the cost (as defined in section 502(5) of the Federal Credit Reform Act of 1990) of the cancellation of any debt under this section, there are authorized to be appropriated to the President such sums as may be necessary for each of the fiscal years 2000 through 2004, which shall remain available until expended.

(j) ANNUAL REPORTS TO THE CONGRESS.—Not later than December 31 of each year, the President shall prepare and transmit to the Committees on Banking and Financial Services, Appropriations, and International Relations of the House of Representatives, and the Committees on Banking, Housing, and Urban Affairs, Foreign Relations, and Appropriations of the Senate a report, which shall be made available to the public, concerning the cancellation of debt under subsection (a), and a detailed description of debt relief provided by the United States as a member of the Paris Club of Official Creditors for the prior fiscal year.

SEC. 502. ACTIONS TO IMPROVE THE PROVISION OF MULTILATERAL DEBT RELIEF.

Title XVI of the International Financial Institutions Act (22 U.S.C. 262p–262p–5) is amended by adding at the end the following:

"SEC. 1623. IMPROVEMENT OF THE HEAVILY INDEBTED POOR COUNTRIES INITIATIVE.

"(a) IMPROVEMENT OF THE HIPC INITIATIVE.—In order to accelerate multilateral debt relief and promote human and economic development and poverty alleviation in heavily indebted poor countries, the Congress urges the President to commence immediately efforts, with the Paris Club of Official Creditors, as well as the International Monetary Fund (IMF), the International Bank for Reconstruction and Development (World Bank), and other appropriate multilateral development institutions to accomplish the following modifications to the Heavily Indebted Poor Countries Initiative:

"(1) FOCUS ON POVERTY REDUCTION, GOOD GOVERNANCE, TRANSPARENCY, AND PARTICIPATION OF CITIZENS.—A country which is otherwise eligible to receive cancellation of debt under the modified Heavily Indebted Poor Countries Initiative may receive such cancellation only if the country has committed, in connection with social and economic reform programs that are jointly developed, financed, and administered by the World Bank and the IMF—

"(A) to enable, facilitate, or encourage the implementation of policy changes and institutional reforms under economic reform programs, in a manner that ensures that such policy changes and institutional reforms are designed and adopted through transparent and participatory processes;

"(B) to adopt an integrated development strategy to support poverty reduction through economic growth, that includes monitorable poverty reduction goals;

"(C) to take steps so that the financial benefits of debt relief are applied to programs to combat poverty (in particular through concrete measures to improve economic infrastructure, basic services in education, nutrition, and health, particularly treatment and prevention of the leading causes of mortality) and to redress environmental degradation;

"(D) to take steps to strengthen and expand the private sector, encourage increased trade and investment, support the development of free markets, and promote broad-scale economic growth;

"(E) to implement transparent policy making and budget procedures, good governance, and effective anticorruption measures;

"(F) to broaden public participation and popular understanding of the principles and goals of poverty reduction, particularly through economic growth, and good governance; and

"(G) to promote the participation of citizens and nongovernmental organizations in the economic policy choices of the government.

"(2) FASTER DEBT RELIEF.—The Secretary of the Treasury should urge the IMF and the World Bank to complete a debt sustainability analysis by December 31, 2000, and determine eligibility for debt relief, for as many of the countries under the modified Heavily Indebted Poor Countries Initiative as possible.

"(b) HEAVILY INDEBTED POOR COUNTRIES REVIEW.—The Secretary of the Treasury, after consulting with the Committees on Banking and Financial Services and International Relations of the House of Representatives, and the Committees on Foreign Relations and Banking, Housing, and Urban Affairs of the Senate, shall make every effort (including instructing the United States Directors at the IMF and World Bank) to ensure that an external assessment of the modified Heavily Indebted Poor Countries Initiative, including the reformed Enhanced Structural Adjustment Facility program as it relates to that Initiative, takes place by December 31, 2001, incorporating the views of debtor governments and civil society, and that such assessment be made public.

"(c) DEFINITION.—The term 'modified Heavily Indebted Poor Countries Initiative' means the multilateral debt initiative presented in the Report of G–7 Finance Ministers on the Köln Debt Initiative to the Köln Economic Summit, Cologne, Germany, held from June 18–20, 1999.

"SEC. 1624. REFORM OF THE ENHANCED STRUCTURAL ADJUSTMENT FACILITY.

"The Secretary of the Treasury shall instruct the United States Executive Directors at the International Bank for Reconstruction and Development (World Bank) and the International Monetary Fund (IMF) to use the voice and vote of the United States to promote the establishment of poverty reduction strategy policies and procedures at the World Bank and the IMF that support countries' efforts under programs developed and jointly administered by the World Bank and the IMF that have the following components:

''(1) The development of country-specific poverty reduction strategies (Poverty Reduction Strategies) under the leadership of such countries that—

''(A) will be set out in poverty reduction strategy papers (PRSPs) that provide the basis for the lending operations of the International Development Association (IDA) and the reformed Enhanced Structural Adjustment Facility (ESAF);

''(B) will reflect the World Bank's role in poverty reduction and the IMF's role in macroeconomic issues;

''(C) will make the IMF's and the World Bank's advice and operations fully consistent with the objectives of poverty reduction through broad-based economic growth; and

''(D) should include—

''(i) implementation of transparent budgetary procedures and mechanisms to help ensure that the financial benefits of debt relief under the modified Heavily Indebted Poor Countries Initiative (as defined in section 1623) are applied to programs that combat poverty; and

''(ii) monitorable indicators of progress in poverty reduction.

''(2) The adoption of procedures for periodic comprehensive reviews of reformed ESAF and IDA programs to help ensure progress toward longer-term poverty goals outlined in the Poverty Reduction Strategies and to allow adjustments in such programs.

''(3) The publication of the PRSPs prior to Executive Board review of related programs under IDA and the reformed ESAF.

''(4) The establishment of a standing evaluation unit at the IMF, similar to the Operations Evaluation Department of the World Bank, that would report directly to the Executive Board of the IMF and that would undertake periodic reviews of IMF operations, including the operations of the reformed ESAF, including—

''(A) assessments of experience under the reformed ESAF programs in the areas of poverty reduction, economic growth, and access to basic social services;

''(B) assessments of the extent and quality of participation in program design by citizens;

''(C) verifications that reformed ESAF programs are designed in a manner consistent with the Poverty Reduction Strategies; and

''(D) prompt release to the public of all reviews by the standing evaluation unit.

''(5) The promotion of clearer conditionality in IDA and reformed ESAF programs that focuses on reforms most likely to support poverty reduction through broad-based economic growth.

''(6) The adoption by the IMF of policies aimed at reforming ESAF so that reformed ESAF programs are consistent with the Poverty Reduction Strategies.

''(7) The adoption by the World Bank of policies to help ensure that its lending operations in countries eligible for debt relief under the modified Heavily Indebted Poor Countries Initiative are consistent with the Poverty Reduction Strategies.

''(8) Strengthening the linkage between borrower country performance and lending operations by IDA and the reformed ESAF on the basis of clear and monitorable indictors.

''(9) Full public disclosure of the proposed objectives and financial organization of the successor to the ESAF at least 90 days before any decision by the Executive Board of the IMF to consider its adoption.''.

SEC. 503. ACTIONS TO FUND THE PROVISION OF MULTILATERAL DEBT RELIEF.

(a) CONTRIBUTIONS FOR DEBT REDUCTIONS FOR THE POOREST COUNTRIES.—The Bretton Woods Agreements Act (22 U.S.C. 286 et seq.) is amended by adding at the end the following:

''SEC. 62. APPROVAL OF CONTRIBUTIONS FOR DEBT REDUCTIONS FOR THE POOREST COUNTRIES.

''For the purpose of mobilizing the resources of the Fund in order to help reduce poverty and improve the lives of residents of poor countries and, in particular, to allow those poor countries with unsustainable debt burdens to receive deeper, broader, and faster debt relief, without allowing gold to reach the open market or otherwise adversely affecting the market price of gold, the Secretary of the Treasury is authorized to instruct the United States Executive Director of the Fund to vote—

''(1) to approve an arrangement whereby the Fund—

''(A) sells a quantity of its gold at prevailing market prices to a member or members in nonpublic transactions sufficient to generate 2.226 billion Special Drawing Rights in profits on such sales;

''(B) immediately after, and in conjunction with each such sale, accepts payment by such member or members of such gold to satisfy existing repurchase obligations of such member or members so that the Fund retains ownership of the gold at the conclusion of such payment;

''(C) uses the earnings on the investment of the profits of such sales through a separate subaccount, only for the purpose of providing debt relief from the Fund under the modified Heavily Indebted Poor Countries (HIPC) Initiative (as defined in section 1623 of the International Financial Institutions Act); and

''(D) shall not use more than 9/14 of the earnings on the investment of the profits of such sales; and

''(2) to support a decision that shall terminate the Special Contingency Account 2 (SCA–2) of the Fund so that the funds in the SCA–2 shall be made available to the poorest countries. Any funds attributable to the United States participation in SCA–2 shall be used only for debt relief from the Fund under the modified HIPC Initiative.''.

(b) CERTIFICATION.—Within 15 days after the United States Executive Director casts the votes necessary to carry out the instruction described in section 62 of the Bretton Woods Agreements Act, the Secretary of the Treasury shall certify to the Congress that neither the profits nor the earnings on the investment of profits from the gold sales made pursuant to the instruction or of the funds attributable to United States participation in SCA–2 will be used to augment the resources of any reserve account of the International Monetary Fund for the purpose of making loans.

SEC. 504. ADDITIONAL PROVISIONS.

(a) PUBLICATION OF IMF OPERATIONAL BUDGETS.—The Secretary of the Treasury shall instruct the United States Executive Director at the International Monetary Fund to use the voice, vote, and influence of the United States to urge vigorously the International Monetary Fund to publish the operational budgets of the International Monetary Fund, on a quarterly basis, not later than one year after the end of the period covered by the budget.

(b) REPORT TO THE CONGRESS SHOWING COSTS OF UNITED STATES PARTICIPATION IN THE INTERNATIONAL MONETARY FUND.—The Secretary of the Treasury shall prepare and transmit to the Committees on Banking and Financial Services, on Appropriations, and on International Relations of the House of Representatives and the Committees on Banking, Housing, and Urban Affairs, on Foreign Relations, and on Appropriations of the Senate a quarterly report, which shall be made readily available to the public, on the costs or benefits of United States participation in the International Monetary Fund and which shall detail the costs and benefits to the United States, as well as valuation gains or losses on the United States reserve position in the International Monetary Fund.

(c) CONTINUATION OF FORGOING OF REIMBURSEMENT OF IMF FOR EXPENSES OF ADMINISTERING ESAF.—The Secretary of the Treasury shall instruct the United States Executive Director at the International Monetary Fund to use the voice, vote, and influence of the United States to urge vigorously the International Monetary Fund to continue to forgo reimbursements of the expenses incurred by the International Monetary Fund in administering the Enhanced Structural Adjustment Facility, until the Heavily Indebted Poor Countries Initiative (as defined in section 1623 of the International Financial Institutions Act) is terminated.

(d) NO GOLD SALES BY INTERNATIONAL MONETARY FUND WITHOUT PRIOR AUTHORIZATION BY THE CONGRESS.—(1) The first sentence of section 5 of the Bretton Woods Agreements Act (22 U.S.C. 286c) is amended in clause (g) by striking ''approve either the disposition of more than 25 million ounces of Fund gold for the benefit of the Trust Fund established by the Fund on May 6, 1976, or the establishment of any additional trust fund whereby resources of the International Monetary Fund would be used for the special benefit of a single member, or of a particular segment of the membership, of the Fund.'' and inserting ''approve any disposition of Fund gold, unless the Secretary certifies to the Congress that such disposition is necessary for the Fund to restitute gold to its members, or for the Fund to provide liquidity that will enable the Fund to meet member country claims on the Fund or to meet threats to the systemic stability of the international financial system.''.

(2) Not less than 30 days prior to the entrance by the United States into international negotiations for the purpose of reaching agreement on the disposition of Fund gold whereby resources of the Fund would be used for the special benefit of a single member, or of a particular segment of the membership of the Fund, the Secretary of the Treasury shall consult with the Committees on Banking and Financial Services, on Appropriations, and on International Relations of the House of Representatives and the Committees on Foreign Relations, on Appropriations, and on Banking, Housing and Urban Affairs of the Senate.

(e) ANNUAL REPORT BY GAO ON CONSISTENCY OF IMF PRACTICES WITH STATUTORY POLICIES.—The Comptroller General of the United States shall annually prepare and submit to the Congress of the United States a written port on the extent to which the practices of the International Monetary Fund are consistent with the policies of the United States, as expressly contained in Federal law applicable to the International Monetary Fund.

TITLE VI—SURVIVOR BENEFITS

SEC. 601. PAYMENT.

(a) PAYMENT AUTHORIZATION.—The Secretary of the Treasury shall pay, out of funds not otherwise appropriated, $100,000 to the survivor, or collectively the survivors, of each of the 14 members of the Armed Forces and the one United States civilian Federal employee who were killed on April 14, 1994, when United States F–15 fighter aircraft mistakenly shot down two UH–60 Black Hawk helicopters over Iraq.

(b) SURVIVOR STATUS.—

(1) MEMBERS OF THE ARMED FORCES INSURED BY SGLI.—In the case of a member of the Armed Forces described in subsection (a) who was insured by a Servicemembers' Group Life Insurance policy (issued under chapter 19 of title 38, United States Code), a survivor of such member for the purposes of subsection (a) shall be any person designated as a beneficiary on the individual's policy.

(2) INDIVIDUALS NOT INSURED BY SGLI.—In the case of a member of the Armed Forces described in subsection (a) who was not insured by a Servicemembers' Group Life Insurance policy (issued under chapter 19 of title 38, United States Code) or the civilian Federal employee described in subsection (a), a survivor of such member or employee for the purposes of subsection (a) shall be any person determined to be a survivor by the Secretary of the Treasury using the provisions of section 5582(b) of title 5, United States Code.

SEC. 602. LIMITATION ON TOTAL AMOUNT OF PAYMENT.

Not more than a total of $1,500,000 may be paid to survivors under section 1.

SEC. 603. LIMITATION ON ATTORNEY FEES.

Notwithstanding any contract, no representative of a survivor may receive more than 10 percent of a payment made under section 1 for services rendered in connection with the survivor's claim for such payment. Any person who violates this section shall be guilty of an infraction and shall be subject to a fine in the amount provided in title 18, United States Code.

SEC. 604. REPORT.

Not later than 6 months after the date of the enactment of this Act, the Secretary of the Treasury shall transmit to the Congress a report describing the payments made under section 1.

TITLE VII—MISCELLANEOUS PROVISIONS

SEC. 701. GRANT OF NATURALIZATION TO PETRA LOVETINSKA. (a) IN GENERAL.—Notwithstanding any other provision of law, Petra Lovetinska shall be naturalized as a citizen of the United States upon the filing of the appropriate application and upon being administered the oath of renunciation and allegiance in an appropriate ceremony pursuant to section 337 of the Immigration and Nationality Act.

(b) DEADLINE FOR APPLICATION AND PAYMENT OF FEES.—Subsection (a) shall apply only if the application for naturalization is filed with appropriate fees within 1 year after the date of the enactment of this Act.

SEC. 702. TRADE ADJUSTMENT ASSISTANCE. (a) ASSISTANCE FOR WORKERS.—Section 245 of the Trade Act of 1974 (19 U.S.C. 2317) is amended—

(1) in subsection (a), by striking ''June 30, 1999'' and inserting ''September 30, 2001''; and

(2) in subsection (b), by striking ''June 30, 1999'' and inserting ''September 30, 2001''.

(b) NAFTA TRANSITIONAL PROGRAM.—Section 250(d)(2) of the Trade Act of 1974 (19 U.S.C. 2331(d)(2)) is amended by striking ''the period beginning October 1, 1998, and ending June 30, 1999, shall not exceed $15,000,000'' and inserting ''the period beginning October 1, 1998, and ending September 30, 2001, shall not exceed $30,000,000 for any fiscal year''.

(c) ADJUSTMENT FOR FIRMS.—Section 256(b) of the Trade Act of 1974 (19 U.S.C. 2346(b)) is amended by striking ''June 30, 1999'' and inserting ''September 30, 2001''.

(d) TERMINATION.—Section 285(c) of the Trade Act of 1974 (19 U.S.C. 2271 note preceding) is amended by striking ''June 30, 1999'' each place it appears and inserting ''September 30, 2001''.

(e) EFFECTIVE DATE.—The amendments made by this section shall be effective as of July 1, 1999.

Following is explantory language on H.R. 3425, as introduced on November 17, 1999.

TITLE I—EMERGENCY SUPPLEMENTAL APPROPRIATIONS

CHAPTER 1

DEPARTMENT OF AGRICULTURE

The conference agreement provides additional resources for damages caused by hurricanes and other natural disasters in North Carolina, Florida and other states.

FARM SERVICE AGENCY

AGRICULTURAL CREDIT INSURANCE FUND PROGRAM ACCOUNT

The conference agreement appropriates additional subsidies for the following programs: $828,000 for direct farm ownership loans (providing for an estimated loan level of $21,951,000); $3,184,000 for guaranteed farm ownership loans (providing for an estimated loan level of $568,627,000); $23,441,000 for direct operating loans (providing for an estimated loan level of $400,000,000); $4,260,000 for unsubsidized guaranteed operating loans (providing for an estimated loan level of $302,158,000); $61,895,000 for subsidized guaranteed operating loans (providing for an estimated loan level of $702,558,000); and $84,949,000 for emergency loans (providing for an estimated loan level of $547,000,000).

The conference agreement meets critical needs to finance the repair or replacement of farm structures or equipment damaged by natural disasters.

EMERGENCY CONSERVATION PROGRAM

The conference agreement provides $50,000,000 for the Emergency Conservation Program.

COMMODITY CREDIT CORPORATION FUND

CROP LOSS ASSISTANCE

The conference agreement provides an additional $186,000,000 for crop loss assistance under the same terms and conditions as in section 801 of Public Law 106–78.

SPECIALTY CROP ASSISTANCE

The conference agreement provides an additional $2,800,000 for specialty crop assistance and makes eligible producers of commodities harvested and placed in warehouses but not sold.

In carrying out the production loss provisions of section 801 of P.L. 106–78, the Secretary of Agriculture shall be expected to take into account quality losses including those related to potato blight, Sclerotinia in sunflowers, and discounts for durum and spring wheat due to lack of milling and baking quality, and grading losses of peanuts and fruits and vegetables (including sweet potatoes) due to excessive moisture and related conditions.

LIVESTOCK ASSISTANCE

The conference agreement provides an additional $10,000,000 for livestock assistance authorized by section 805 of Public Law 106–78. The conference agreement further provides that the Secretary of Agriculture may use this additional amount to provide assistance to persons who raise livestock owned by other persons for income losses sustained with respect to livestock during 1999 if the Secretary finds that such losses are the result of natural disasters.

NATURAL RESOURCES CONSERVATION SERVICE

WATERSHED AND FLOOD PREVENTION OPERATIONS

The conference agreement provides an additional $80,000,000 for Watershed and Flood Prevention Operations to repair damages to waterways and watersheds resulting from natural disasters.

RURAL HOUSING SERVICE

RURAL HOUSING INSURANCE FUND PROGRAM ACCOUNT

The conference agreement appropriates additional subsidies of $4,265,000 for section 502 direct loans (providing for an estimated loan level of $50,000,000), $4,584,000 for section 504 housing repair loans (providing for an estimated loan level of $15,000,000), and $2,250,000 for section 514 farm labor housing (providing for an estimated loan level of $5,000,000).

RURAL HOUSING ASSISTANCE GRANTS

The conference agreement provides an additional $14,500,000 for rural housing assistance grants of which $10,000,000 is for section 504 very low-income housing repair and $4,500,000 is for section 514 farm labor housing.

GENERAL PROVISIONS—THIS CHAPTER

SEC. 101. The conference agreement directs the Secretary of Agriculture to provide up to $20,000,000 in assistance under the noninsured crop assistance program, without any requirement for an area loss, to producers located in a county with respect to which a natural disaster was declared by the Secretary or a major disaster or emergency was declared by the President under the Robert T. Stafford Disaster Relief and Emergency Assistance Act.

SEC. 102. The conference agreement includes language making a technical correction to section 814 of Public Law 106–78 regarding crop insurance premium discounts.

SEC. 103. The conference agreement includes language permitting the Secretary of Agriculture to obligate not to exceed $4,700,000 of previously appropriated funds for mandatory livestock private reporting.

SEC. 104. The conference agreement includes language which permits the Secretary of Agriculture to provide assistance to producers or first-handlers for the 1999 crop of cottonseed, and which provides special competitive provisions for extra long staple cotton.

The Farm Service Agency of the Department of Agriculture has indicated that funds made available by previous appropriations Acts for market loss assistance may exceed the amounts necessary to carry out the requirements of those Acts. If the Secretary determines that this is the case, the conference agreement directs that such funds shall be applied first to fund activities related to mandatory livestock price reporting, second to fund assistance to producers or first-handlers for the 1999 crop of cottonseed, and third to fund activities related to special competitive provisions for extra long staple cotton. Within 30 days of enactment of this Act, the Secretary shall report to the Appropriations Committees of the House and the Senate on the status of funds previously appropriated for market loss assistance in Public Laws 105–277 and 106–78, and the plan and timetable for obligation of any excess funds. Further, the Secretary shall report periodically (but no less frequently than quarterly) on the status of such funds and plans until all funds previously appropriated for market loss assistance are exhausted.

SEC. 105. The conference agreement requires that the entire amount necessary to carry out this chapter shall be available only to the extent that an official budget request for the entire amount, that includes designation of the entire amount of the request as an emergency requirement, is transmitted by the President to the Congress and that the entire amount is designated by the Congress as an emergency requirement.

CHAPTER 2

FEDERAL EMERGENCY MANAGEMENT AGENCY

DISASTER RELIEF

The President has proposed that of the funding made available in Public Law 106–74, up to $429,149,000 would be available for property acquisition and relocation assistance for residential homeowner victims of Hurricane Floyd. Since current regulations and policies do not adequately address this type of assistance, the President's proposal would be to provide this funding to the affected states through the section 404 program of the Stafford Act.

There is no doubt that Hurricane Floyd caused significant damage and loss of property. The Congress is committed to providing appropriate assistance to affected property owners. However, the conferees are concerned that FEMA does not have a structured program for buyouts and relocation of structures, including eligibility criteria, oversight procedures, procedures for affected states to prioritize projects, requirements for the submission of state and local buyout plans, procedures for cost-benefit analysis, and the process for measuring program results.

The appropriate Congressional committees of jurisdiction should hold hearings early in the next session of Congress to explore fully the extent of the problem which exists because of damage caused by Hurricane Floyd and surrounding events, and the benefits and problems associated with buyouts and relocations. The authorizing committees should

then recommend solutions to those problems, keeping in mind the need to control disaster relief costs while addressing the most compelling needs. Such hearings could then serve as the basis for FEMA to undertake a rulemaking which includes a significant comment period and would result in a policy which could be applied in a uniform manner to ensure that all individuals suffering losses are treated in a consistent and equitable manner.

In the interim, the conferees have agreed to provide authority to spend up to $215,000,000 for buyout of homeowners (or the relocation of structures) for residences that have been made uninhabitable by flooding caused by Hurricane Floyd, and surrounding events, which are located in the 100-year flood plain. FEMA is required to promulgate interim regulations not later than December 31, 1999, pertaining to the buyout program. The conferees are aware that the authority provided does not give FEMA the same flexibility afforded under the section 404 program and FEMA is directed to report to the Committees on Appropriations of the House and Senate on any significant problems which arise as a result of this decreased flexibility.

The conferees continue to have serious concerns about the dissemination of accurate and useful information to water well owners about testing for contamination and implementing decontamination procedures for household drinking water in flood areas. The conferees encourage FEMA to continue to work with expert organizations, like the National Ground Water Association, in developing information about proper decontamination practices and procedures.

TITLE II—OTHER APPROPRIATIONS MATTERS

DEPARTMENT OF AGRICULTURE—OTHER ITEMS

The conference agreement expects the Agricultural Marketing Service [AMS] to continue to assess the existing inventories of cranberries and to determine whether or not there is a surplus and continued low price in fiscal year 2000. If there is a surplus inventory of cranberries and continued low price, the Department is expected to purchase surplus cranberries under the authorities of section 32 for donation to schools, institutions, and other domestic feeding programs or for humanitarian food aid.

The conference agreement encourages the Natural Resources Conservation Service to assist in the construction of the Snake River project in Warren, Minnesota.

The conference agreement directs the General Accounting Office (GAO), in close consultation with the Department of Agriculture, to transmit to the Committees on Appropriations, Agriculture and Judiciary by June 30, 2000 a report on current practices and policies in the states concerning bonds to secure payment of employee wage obligations of ''farm labor contractors.'' The report shall include (a) a summary of state law requirements for such bonding of farm labor contractors; (b) an analysis of the role of farm labor contractors in the allocation and provision of farm labor for work performed by seasonal and migrant agricultural workers and the effect that state law bonding requirements have had on the availability of farm labor contracting services and farm labor; (c) an economic assessment of the availability, reliability and costs of such bonds for farm labor contractors; and (d) an assessment of the effect of such bond requirements on total farm labor compensation costs and benefits.

SECTIONS 201 and 202. The bill includes new sections related to Food and Drug Administration facilities.

SEC. 203. The conference agreement includes language which permits the Secretary of Agriculture to use funds provided for fiscal year 2000 for rural housing assistance grants for a pilot project to provide home ownership for farm workers and workers involved in the processing of farm products in the Salinas, California area.

SEC. 204. The conference agreement includes language which directs the Secretary of Agriculture to use $16,000,000 of Commodity Credit Corporation funds for replacement of commercial and non-commercial citrus trees removed to control citrus canker.

SEC. 205. The conference agreement includes language which provides for continuation of crop insurance revenue insurance pilots, and which provides for expansion of other crop insurance pilots. The Department is directed to report to the Appropriations Committees of the House and Senate fifteen days prior to the implementation of any expansion of crop insurance pilot projects. This report will be expected to display the scope, impact, and justification for the expansion.

SEC. 206. The conference agreement includes language which revises crop insurance sales closing dates.

SEC. 207. The conference agreement includes language which allows funding to be provided for certain flood-related losses in the State of Oregon.

SEC. 208. The conference agreement includes language which provides $5,000,000 and allows funding to be provided to repair storm-related damage to the Tillamook Railroad.

SEC. 209. The conference agreement includes language which provides that the Congressional Hunger Center may invest funds for hunger fellowships and expend income from such funds, and that previously appropriated funds may be paid directly to the Congressional Hunger Center.

SEC. 210. The conference agreement permits the Secretary of Agriculture to reprogram funds to provide up to $100,000 for the cost of guaranteed loans authorized by section 306 of the Rural Electrification Act of 1936.

SEC. 211. The conference agreement includes language which repeals section 755(b) of Public Law 106–78, which is not required because the identical provision was enacted in section 1 of Public Law 106–47.

SEC. 212. The conference agreement includes a provision which amends Section 602(b)(2) of the Small Business Reauthorization Act of 1997 to include the Departments of Commerce, Justice and State as participating agencies in the HUBZone program.

SEC. 213. SPECTRUM AUCTION.—The conference agreement includes a general provision regarding the competitive auction of communication frequencies, a provision which replaces a version included in the Department of Defense Appropriations Act, 2000 (Public Law 106–79).

SEC. 214. PROGRESS PAYMENTS.—The conference agreement includes a general provision that adjusts the Department of Defense procedures for making progress payments, a provision which replaces a version included in the Department of Defense Appropriations Act, 2000 (Public Law 106–79).

SEC. 215. PROMPT PAYMENT.—The conference agreement includes a general provision that adjusts payment procedures and policies for valid invoices covered by the Prompt Payment Act, a provision which replaces a version included in the Department of Defense Appropriations Act, 2000 (Public Law 106–79).

SEC. 216. STUDY REGARDING TAIWAN AND THE PEOPLE'S REPUBLIC OF CHINA.—The conference agreement includes a general provision requiring the submission of a joint report by the Office of Net Assessment (Office of the Secretary of Defense) and the United States Pacific Command regarding implementation of relevant sections of the Taiwan Relations Act, and gaps in relevant knowledge about the People's Republic of China's intentions and capabilities as they might affect the current and future military balance between Taiwan and the PRC.

SEC. 217. *DoD-VA Study Regarding Low-Level Chemical Exposures.* The conference agreement include general provision requiring the submission of a joint report by the Secretaries of Defense and Veterans Affairs assessing the adequacy of medical research activities investing the health effects of low-level chemical exposures of Persian Gulf military forces while serving in the Southwest Asia theater of operations.

FISCAL YEAR 2000 APPROPRIATIONS ACT CLARIFICATION

The conferees agree that it was the intention of Congress that the requirements of section 8149 of Public Law 106–79 in no way supercede the requirements of section 8154 of that Act.

SEC. 218. *Army Readiness Enhancements.* The conference agreement includes a general provision providing $100,000,000 to the Department of the Army, to address existing readiness shortfalls. The provision permits these funds to be used to initiate testing and validation of the new Army Vision concept. The conferees direct that none of the funds provided in this section may be obligated until 30 days after the Chief of Staff of the Army reports to the congressional defense committees the specific plan to utilize these funds, and, if funds are designated for the Army Vision concept, the relationship between these expenditures and the fiscal year 2001 Army budget request for continuation of these initiatives.

SEC. 219. *Transfer of Funds—Department of Defense Appropriations Act, 2000.* The conference agreement includes a general provision transferring $500,000 of sums appropriated from Research, Development, Test and Evaluation, Army (from funds designated for ''next generation command and control system'') to Operation and Maintenance, Defense-Wide. These funds shall be made available to the Office of Economic Adjustment to complete the Washington Square project, initiated by the Department of Defense in previous years.

SEC. 220. The conference agreement includes a provision prohibiting the imposition on the Federal government or its contractors of any financial responsibility requirement associated with the operation of Federal transuranic waste management facilities.

SEC. 221. The conference agreement includes a provision deauthorizing a certain portion of the Newport Harbor, Rhode Island, project of the U.S. Army Corps of Engineers. The provision redesignates two other portions of the project as anchorage areas.

SEC. 222. The conference agreement includes $1,250,000 to purchase the Elias tract to be included in the Wertheim National Wildlife Refuge in Brookhaven, New York.

SEC. 223. A death gratuity has been provided to the widow of John H. Chafee, late a Senator from the State of Rhode Island.

SEC. 224. A provision has been included authorizing a change in the pay levels of the Director and Deputy Director, Congressional Budget Office.

FLORIDA—PANAMA CITY: COASTAL SYSTEMS STATIONS

The conferees recognize and appreciate the willingness of the State of Florida to provide funding for the entrance gate and highway improvements at Coastal System Stations, Panama City, Florida and the willingness of Bay County to be a partner in this undertaking. These entities, and the Navy, are encouraged to work together to ensure a timely solution is reached which is beneficial to both the base and the local community.

SEC. 225. The conference agreement includes a provision that provides in addition to amounts otherwise made available in Public Law 106–69 $1,750,000 for metropolitan buses and bus facilities for Twin Cities, Minnesota; $750,000 for Santa Clarita, California bus maintenance facility; $1,000,000 for Lincoln, Nebraska bus maintenance facility; and $2,500,000 for Anchorage Alaska 2001 Special Olympics Winter Games buses and bus facilities. The provision also stipulates that of the funds made available for the national corridor planning and development and coordinated border infrastructure programs $2,000,000 shall be available for the planning and design of a highway corridor between Dothan, Alabama and Panama City, Florida. The provision also makes a number of technical corrections to previously appropriated bus and bus facilities project designations in Public Laws 106–69 and 105–277.

SEC. 226. The conference agreement includes a provision prohibiting the use of funds made available in Public Law 106–69 or in any other act to decommission or reduce operations of United States Coast Guard WYTL harbor tug boats.

SEC. 227. The conference agreement includes a provision that amends section 351 of Public Law 106–69 to make available $10,000,000 of funds appropriated or limited in the Fiscal Year 2000 Department of Transportation and Related Agencies Appropriations Act to the Federal Highway Administration and the National Highway Traffic Safety Administration for the national advanced driving simulator.

SEC. 228. The conference agreement includes a provision that waives the cost-sharing requirements for asphalt research at the Western Research Institute for fiscal years 1998, 1999 and 2000.

SEC. 229. The conference agreement includes a provision that makes technical changes to section 366 of Public Law 106–69 regarding the conveyance of land in the city of Safford, Arizona.

SEC. 230. The conference agreement includes a provision which allows the Woodrow Wilson Bridge project to be included on the State and regional transportation improvement program plans pending resolution of associated issues.

SEC. 231. The conference agreement includes a provision which continues expiring exemptions allowing aircraft maintenance to be performed in the United States for certain aircraft in Hawaii, and for other purposes.

SEC. 232. The conference agreement includes advance appropriations totalling $60,000,000 for the engineering, design, and construction activities to convert the James A. Farley Post Office building in New York City into a train station and commercial center. Of this total $20,000,000 is available on October 1, 2000; $20,000,000 on October 1, 2001; and $20,000,000 on October 1, 2002.

SEC. 233. The conference agreement includes a technical correction providing for the continuation of temporary authority for the General Services Administration to transfer surplus Federal property to State and local governments for law enforcement and emergency response purposes.

SEC. 234. The conference agreement includes a provision providing transfer authority to federal agencies for the implementation of agency business continuity and contingency plans related to Y2K compliance. Federal agencies have been tasked to develop business continuity and contingency plans in the event that their operations are affected by Y2K-related disruptions. It is essential that Federal agencies experiencing or affected by Y2K problems have the ability to implement such plans in order to maintain their business operations and continue providing services. This section is intended to ensure that funding is available during the period Congress is not in session for Federal agencies to Implement their business continuity and contingency plans in furtherance of Y2K compliance.

SEC. 235. The conference agreement includes a provision providing that funds available to the Executive Office of the President, Office of Administration, for a capital investment plan under P.L. 106–58 shall be available for two years.

SEC. 236. The conference agreement includes a provision extending federal agency reporting requirements.

SEC. 237. The conference agreement provides $3,000,000 for the Office of National Drug Control Policy, making funds available to the United States Olympic Committee for its anti-doping program.

SEC. 238. The conference agreement includes a provision adjusting the salary level of the U.S. Customs Service Commissioner.

SEC. 239. The conference agreement includes a technical correction to legislation providing for an acting Treasury Inspector General for Tax Administration.

SEC. 240. On September 21, 1999, the Administration forwarded to Congress a package of budget amendments, including a request for additional funding for the United States Secret Service. However, Congress had already approved the Treasury and General Government Appropriations Act, 2000.

To address this issue, a provision is included which provides an additional $10,000,000 to the United States Secret Service for salaries and expenses, and which in addition directs the Secretary of the Treasury to transfer $21,000,000 to the United States Secret Service for new full-time-equivalents (FTE). The conferees are aware that these funds are necessary to meet the additional workload requirements associated with the Secret Service's protective and investigative operations. The conferees regret that the Administration did not propose additional resources during the regular fiscal year 2000 appropriations process given that early separations and average overtime for agents are at unacceptably high rates.

The conferees direct the Administration to submit, as part of its annual budget submission, a summary of workload trends for field agents including, but not limited to, average overtime and early separations. The conferees further directed the United States Secret Service, Assistant Director, Office of Investigations, to provide quarterly reports to the Committees on Appropriations on workforce retention and workload balance including, but not limited to, investigative and protective workloads, recruitment, and staffing by field office.

UNITED STATES SECRET SERVICE

PATHOGEN SENSOR SYSTEMS

The conferees commend the efforts of the Secret Service to improve its ability to detect biological agents. The conferees encourage the Secret Service to monitor the development of biological detector technology through coordination with the Defense Advanced Research Projects Agency (DARPA) for pathogen sensor systems. The conferees direct the Secret Service to report on the possible benefits of this technology to the Committees on Appropriations within 120 days of enactment of this Act.

SEC. 241. The conference agreement includes a provision to extend the authority for agencies to submit Accountability Reports under the Government Management Reform Act of 1994.

SEC. 242. The conference agreement amends Public Law 106–74 to include seven additional economic development initiative projects.

The following table reflects the appropriation amounts for title I and title II in thousands of dollars.

Title I—Emergency Supplemental Appropriations: Chapter 1, Department of Agriculture

Farm Service Agency:	
Agricultural Credit Insurance Fund Program Account:	
Loan authorizations:	
Farm ownership loans:	
Direct	$(21,951)
Guaranteed	(568,627)
Subtotal	(590,578)
Farm operating loans:	
Direct	(400,000)
Guaranteed unsubsidized	(302,158)
Guaranteed subsidized	(702,558)
Subtotal	(1,404,716)
Emergency disaster loans	(547,000)
Total, Loan authorizations	(2,542,294)
Loan subsidies:	
Farm ownership loans:	
Direct (contingent emergency appropriations)	828
Guaranteed (contingent emergency appropriations)	3,184
Subtotal	4,012
Farm operating loans:	
Direct (contingent emergency appropriations)	23,441
Guaranteed unsubsidized (contingent emergency appropriations)	4,260
Guaranteed subsidized (contingent emergency appropriations)	61,895
Subtotal	89,596
Emergency disaster loans (contingent emergency appropriations)	84,949
Total, Farm Service Agency	178,557
Commodity Credit Corporation Fund:	
Crop loss assistance (contingent emergency appropriations)	186,000
Specialty crop assistance (contingent emergency appropriations)	2,800
Livestock assistance (contingent emergency appropriations)	10,000
Total, Commodity Credit Corporation Fund	198,800
Natural Resources Conservation Service:	
Emergency conservation program (contingent emergency appropriations)	50,000

Title I—Emergency Supplemental Appropriations: Chapter 1, Department of Agriculture—Continued	
Watershed and flood prevention operations (contingent emergency appropriations)	80,000
Total, Natural Resources Conservation Service	130,000
Rural Housing Service:	
Rural Housing Insurance Fund Program Account:	
Loan authorization:	
Single family (sec. 502)	(50,000)
Housing repair (sec. 504)	(15,000)
Farm labor (sec. 514)	(5,000)
Subtotal	(70,000)
Loan subsidies:	
Single family (sec. 502) (contingent emergency appropriations)	4,265)
Housing repair (sec. 504) (contingent emergency appropriations)	4,584
Farm labor (sec. 514) (contingent emergency appropriations)	2,250
Total, Rural Housing Insurance Fund Program Account	11,099
Rural housing assistance grants (contingent emergency appropriations)	14,500
Total, Rural Housing Service	25,599
General Provisions:	
Noninsured crop disaster assistance program (contingent emergency appropriations)	20,000
Total, title I:	
New budget (obligational) authority	552,956
(Loan authorization)	(2,612,294)
Title II—Other Appropriations Matters	
Department of Agriculture:	
Citrus canker/tree replacement (contingent emergency appropriations)	$16,000
Crop insurance pilot programs (contingent emergency appropriations)	1,000
Harney County losses (contingent emergency appropriations)	1,090
Tillamook Railroad disaster repairs (contingent emergency appropriations)	5,000
Department of Defense:	
Operation and Maintenance, Army: Army readiness enhancements	100,000
Operation and Maintenance, Defense-wide: Washington Square project (by transfer)	(500)
Title II—Other Appropriations Matters—Continued	
Department of the Interior:	
National Park Service: Land and water conservation fund	1,250
Legislative Branch:	
Payments to Widows and heirs of Deceased Members of Congress: Gratuities, deceased Member	137
Department of Transportation:	
Federal Transit Administration: Capital investments grants (Highway Trust Fund, Mass Transit Account): Buses and bus-related facilities	6,000
Federal Railroad Administration: Pennsylvania Station redevelopment project (advance appropriations)	60,000
Department of the Treasury:	
United States Secret Service: Salaries and expenses	10,000
(By transfer)	(21,000)
Executive Office of the President:	
Office of National Drug Control Policy	3,000
Total, title II:	
New budget (obligational) authority	203,477
Appropriations	(120,387)
Contingent emergency appropriations	(23,090)
Advance appropriations	(60,000)
(By transfer)	(21,500)
(Loan authorization)	(2,612,294)
Grand total, all titles:	
New budget (obligational) authority	756,433
Appropriations	(120,387)
Contingent emergency appropriations	(576,046)
Advance appropriations	(60,000)
(By transfer)	(21,500)
(Loan authorization)	(2,612,294)
Congressional Budget Recap	
Scorekeeping adjustments:	
Advance appropriations	−60,000
Total, adjustments	−60,000
Total (including adjustments)	696,433
Amounts in this bill	(756,433)
Scorekeeping adjustments	(−60,000)
Total mandatory and discretionary	696,433
Mandatory	(137)
Discretionary	(696,296)

TITLE III

FISCAL YEAR 2000 OFFSETS AND RESCISSIONS

The conference agreement includes several offsets and rescissions.

TITLE IV—CANYON FERRY RESERVOIR, MONTANA

The conference agreement includes a provision making technical corrections to the Canyon Ferry Reservoir, Montana, Act as incorporated in title X of division C of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999.

TITLE IV—INTERNATIONAL DEBT RELIEF

The conference agreement contains new language authorizing certain transactions involving gold held by the International Monetary Fund for the purpose of debt relief of heavily indebted poor countries. The managers have also included statutory language providing policy guidance to the United States Government and its executive director at the International Monetary Fund on Several matters. Language is also included to require forgiveness of debt owed to the United States when specified conditions are met.

TITLE VII—MISCELLANEOUS PROVISIONS

SEC. 702. TRADE ACT AUTHORIZATION.—The conference agreement includes language amending section 245 of the Trade Act of 1974, as amended, to authorize appropriations to the Department of Labor through September 30, 2000 of such sums as may be necessary to administer the general TAA and NAFTA-related TAA programs of Chapter 2 of Title II of that Act. The provision caps NAFTA training expenses at $30,000,000.

In addition, the provision amends section 256 of the Trade Act of 1974 to authorize appropriations to the Secretary of Commerce through September 30, 2001 of such sums as may be necessary to administer the TAA for firms program.

The conference agreement would enact the provisions of H.R. 3426 as introduced on November 17, 1999. The text of that bill follows:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BBA; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) REFERENCES TO THE BALANCED BUDGET ACT OF 1997.—In this Act, the term ''BBA'' means the Balanced Budget Act of 1997 (Public Law 105–33).

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

(a) ADJUSTMENT FOR MEDICALLY COMPLEX PATIENTS UNTIL ESTABLISHMENT OF REFINED CASE-MIX ADJUSTMENT.—For purposes of computing payments for covered skilled nursing facility services under paragraph (1) of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) for such services furnished on or after April 1, 2000, and before the date described in subsection (c), the Secretary of Health and Human Services shall increase by 20 percent the adjusted Federal per diem rate otherwise determined under paragraph (4) of such section (but for this section) for covered skilled nursing facility services for RUG–III groups described in subsection (b) furnished to an individual during the period in which such individual is classified in such a RUG–III category.

(b) GROUPS DESCRIBED.—The RUG–III groups for which the adjustment described in subsection (a) applies are SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2, CA1, RHC, RMC, and RMB as specified in Tables 3 and 4 of the final rule published in the Federal Register by the Health Care Financing Administration on July 30, 1999 (64 Fed. Reg. 41684).

(c) DATE DESCRIBED.—For purposes of subsection (a), the date described in this subsection is the later of—

(1) October 1, 2000; or

(2) the date on which the Secretary implements a refined case mix classification system under section 1888(e)(4)(G)(i) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(G)(i)) to better account for medically complex patients.

(d) INCREASE FOR FISCAL YEARS 2001 AND 2002.—

(1) IN GENERAL.—For purposes of computing payments for covered skilled nursing facility services under paragraph (1) of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) for covered skilled nursing facility services furnished during fiscal years 2001 and 2002, the Secretary of Health and Human Services shall increase by 4.0 percent for each such fiscal year the adjusted Federal per diem rate otherwise determined under paragraph (4) of such section (but for this section).

(2) ADDITIONAL PAYMENT NOT BUILT INTO THE BASE.—The Secretary of Health and Human Services shall not include any additional payment made under this subsection in updating the Federal per diem rate under section 1888(e)(4) of that Act (42 U.S.C. 1395yy(e)(4)).

SEC. 102. AUTHORIZING FACILITIES TO ELECT IMMEDIATE TRANSITION TO FEDERAL RATE.

(a) IN GENERAL.—Section 1888(e) (42 U.S.C. 1395yy(e)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (11)''; and

(2) by adding at the end the following new paragraph:

''(11) PERMITTING FACILITIES TO WAIVE 3-YEAR TRANSITION.—Notwithstanding paragraph (1)(A), a facility may elect to have the amount of the payment for all costs of covered skilled nursing facility services for each day of such services furnished in cost reporting periods beginning no earlier than 30 days before the date of such election determined pursuant to paragraph (1)(B).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to elections made on or after December 15, 1999, except that no election shall be effective under such amendments for a cost reporting period beginning before January 1, 2000.

SEC. 103. PART A PASS-THROUGH PAYMENT FOR CERTAIN AMBULANCE SERVICES, PROSTHESES, AND CHEMOTHERAPY DRUGS.

(a) IN GENERAL.—Section 1888(e) (42 U.S.C. 1395yy(e)) is amended—

(1) in paragraph (2)(A)(i)(II), by striking ''services described in clause (ii)'' and inserting ''items and services described in clauses (ii) and (iii)'';

(2) by adding at the end of paragraph (2)(A) the following new clause:

''(iii) EXCLUSION OF CERTAIN ADDITIONAL ITEMS AND SERVICES.—Items and services described in this clause are the following:

''(I) Ambulance services furnished to an individual in conjunction with renal dialysis services described in section 1861(s)(2)(F).

''(II) Chemotherapy items (identified as of July 1, 1999, by HCPCS codes J9000–J9020; J9040–J9151; J9170–J9185; J9200–J9201; J9206–J9208; J9211; J9230–J9245; and J9265–J9600 (and as subsequently modified by the Secretary)) and any additional chemotherapy items identified by the Secretary.

''(III) Chemotherapy administration services (identified as of July 1, 1999, by HCPCS codes 36260–36262; 36489; 36530–36535; 36640; 36823; and 96405–96542 (and as subsequently modified by the Secretary)) and any additional chemotherapy administration services identified by the Secretary.

''(IV) Radioisotope services (identified as of July 1, 1999, by HCPCS codes 79030–79440 (and as subsequently modified by the Secretary)) and any additional radioisotope services identified by the Secretary.

''(V) Customized prosthetic devices (commonly known as artificial limbs or components of artificial limbs) under the following HCPCS codes (as of July 1, 1999 (and as subsequently modified by the Secretary)), and any additional customized prosthetic devices identified by the Secretary, if delivered to an inpatient for use during the stay in the skilled nursing facility and intended to be used by the individual after discharge from the facility: L5050–L5340; L5500–L5611; L5613–L5986; L5988; L6050–L6370; L6400–L6880; L6920–L7274; and L7362–7366.''; and

(3) by adding at the end of paragraph (9) the following: ''In the case of an item or service described in clause (iii) of paragraph (2)(A) that would be payable under part A but for the exclusion of such item or service under such clause, payment shall be made for the item or service, in an amount otherwise determined under part B of this title for such item or service, from the Federal Hospital Insurance Trust Fund under section 1817 (rather than from the Federal Supplementary Medical Insurance Trust Fund under section 1841).''.

(b) CONFORMING FOR BUDGET NEUTRALITY BEGINNING WITH FISCAL YEAR 2001.—

(1) IN GENERAL.—Section 1888(e)(4)(G) (42 U.S.C. 1395yy(e)(4)(G)) is amended by adding at the end the following new clause:

''(iii) ADJUSTMENT FOR EXCLUSION OF CERTAIN ADDITIONAL ITEMS AND SERVICES.—The Secretary shall provide for an appropriate proportional reduction in payments so that beginning with fiscal year 2001, the aggregate amount of such reductions is equal to the aggregate increase in payments attributable to the exclusion effected under clause (iii) of paragraph (2)(A).''.

(2) CONFORMING AMENDMENT.—Section 1888(e)(8)(A) (42 U.S.C. 1395yy(e)(8)(A)) is amended by striking ''and adjustments for variations in labor-related costs under paragraph (4)(G)(ii)'' and inserting ''adjustments for variations in labor-related costs under paragraph (4)(G)(ii), and adjustments under paragraph (4)(G)(iii)''.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments made for items and services furnished on or after April 1, 2000.

SEC. 104. PROVISION FOR PART B ADD-ONS FOR FACILITIES PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT.

(a) IN GENERAL.—Section 1888(e)(3) (42 U.S.C. 1395yy(e)(3)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by inserting ''or, in the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), the RUGS–III rate received by the facility during the cost reporting period beginning in 1997'' after ''to non-settled cost reports''; and

(B) in clause (ii), by striking ''furnished during such period'' and inserting ''furnished during the applicable cost reporting period described in clause (i)''; and

(2) by striking subparagraph (B) and inserting the following new subparagraph:

''(B) UPDATE TO FIRST COST REPORTING PERIOD.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the applicable cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase minus 1.0 percentage point.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the enactment of section 4432(a) of BBA.

SEC. 105. SPECIAL CONSIDERATION FOR FACILITIES SERVING SPECIALIZED PATIENT POPULATIONS.

(a) IN GENERAL.—Section 1888(e) (42 U.S.C. 1395yy(e)), as amended by section 102(a)(1), is further amended—

(1) in paragraph (1), by striking ''subject to paragraphs (7) and (11)'' and inserting ''subject to paragraphs (7), (11), and (12)''; and

(2) by adding at the end the following new paragraph:

''(12) PAYMENT RULE FOR CERTAIN FACILITIES.—

''(A) IN GENERAL.—In the case of a qualified acute skilled nursing facility described in subparagraph (B), the per diem amount of payment shall be determined by applying the non-Federal percentage and Federal percentage specified in paragraph (2)(C)(ii).

''(B) FACILITY DESCRIBED.—For purposes of subparagraph (A), a qualified acute skilled nursing facility is a facility that—

''(i) was certified by the Secretary as a skilled nursing facility eligible to furnish services under this title before July 1, 1992;

''(ii) is a hospital-based facility; and

''(iii) for the cost reporting period beginning in fiscal year 1998, the facility had more than 60 percent of total patient days comprised of patients who are described in subparagraph (C).

''(C) DESCRIPTION OF PATIENTS.—For purposes of subparagraph (B), a patient described in this subparagraph is an individual who—

''(i) is entitled to benefits under part A; and

''(ii) is immuno-compromised secondary to an infectious disease, with specific diagnoses as specified by the Secretary.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply for the period beginning on the date on which the first cost reporting period of the facility begins after the date of the enactment of this Act and ending on September 30, 2001, and applies to skilled nursing facilities furnishing covered skilled nursing facility services on the date of the enactment of this Act for which payment is made under title XVIII of the Social Security Act.

(c) REPORT TO CONGRESS.—Not later than March 1, 2001, the Secretary of Health and Human Services shall assess the resource use of patients of skilled nursing facilities furnishing services under the medicare program who are immuno-compromised secondary to an infectious disease, with specific diagnoses as specified by the Secretary (under paragraph (12)(C), as added by subsection (a), of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e))) to determine whether any permanent adjustments are needed to the RUGs to take into account the resource uses and costs of these patients.

SEC. 106. MEDPAC STUDY ON SPECIAL PAYMENT FOR FACILITIES LOCATED IN HAWAII AND ALASKA.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of skilled nursing facilities furnishing covered skilled nursing facility services (as defined in section 1888(e)(2)(A) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)) to determine the need for an additional payment amount under section 1888(e)(4)(G) of such Act (42 U.S.C. 1395yy(e)(4)(G)) to take into account the unique circumstances of skilled nursing facilities located in Alaska and Hawaii.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit a report to Congress on the study conducted under subsection (a).

SEC. 107. STUDY AND REPORT REGARDING STATE LICENSURE AND CERTIFICATION STANDARDS AND RESPIRATORY THERAPY COMPETENCY EXAMINATIONS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study that—

(1) identifies variations in State licensure and certification standards for health care providers (including nursing and allied health professionals) and other individuals providing respiratory therapy in skilled nursing facilities;

(2) examines State requirements relating to respiratory therapy competency examinations for such providers and individuals; and

(3) determines whether regular respiratory therapy competency examinations or certifications should be required under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for such providers and individuals.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the results of the study conducted under this section, together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.

Subtitle B—PPS Hospitals

SEC. 111. MODIFICATION IN TRANSITION FOR INDIRECT MEDICAL EDUCATION (IME) PERCENTAGE ADJUSTMENT.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii)(42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (IV), by striking ''and'' at the end;

(2) by redesignating subclause (V) as subclause (VI);

(3) by inserting after subclause (IV) the following new subclause:

''(V) during fiscal year 2001, 'c' is equal to 1.54; and''; and

(4) in subclause (VI), as so redesignated, by striking ''2000'' and inserting ''2001''.

(b) SPECIAL PAYMENTS TO MAINTAIN 6.5 PERCENT IME PAYMENT FOR FISCAL YEAR 2000.—

(1) ADDITIONAL PAYMENT.—In addition to payments made to each subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) under section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B))) which receives payment for the direct costs of medical education for discharges occurring in fiscal year 2000, the Secretary of Health and Human Services shall make one or more payments to each such hospital in an amount which, as estimated by the Secretary, is equal in the aggregate to the difference between the amount of payments to the hospital under such section for such discharges and the amount of payments that would have been paid under such section for such discharges if ''c'' in clause (ii)(IV) of such section equalled 1.6 rather than 1.47. Additional payments made under this subsection shall be made applying the same structure as applies to payments made under section 1886(d)(5)(B) of such Act.

(2) NO EFFECT ON OTHER PAYMENTS OR DETERMINATIONS.—In making such additional payments, the Secretary shall not change payments, determinations, or budget neutrality adjustments made for such period under section 1886(d) of such Act (42 U.S.C. 1395ww(d)).

(c) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by inserting ''or any additional payments under such paragraph resulting from the application of section 111 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999'' after ''Balanced Budget Act of 1997''.

SEC. 112. DECREASE IN REDUCTIONS FOR DISPROPORTIONATE SHARE HOSPITALS; DATA COLLECTION REQUIREMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(F)(ix)(42 U.S.C. 1395ww(d)(5)(F)(ix)) is amended—

(1) in subclause (III), by striking ''during fiscal year 2000'' and inserting ''during each of fiscal years 2000 and 2001'';

(2) by striking subclause (IV);

(3) by redesignating subclauses (V) and (VI) as subclauses (IV) and (V), respectively; and

(4) in subclause (IV), as so redesignated, by striking ''reduced by 5 percent'' and inserting ''reduced by 4 percent''.

(b) DATA COLLECTION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) to submit to the Secretary, in the cost reports submitted to the Secretary by such hospital for discharges occurring during a fiscal year, data on the costs incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated, including non-medicare bad debt, charity care, and charges for medicaid and indigent care.

(2) EFFECTIVE DATE.—The Secretary shall require the submission of the data described in paragraph (1) in cost reports for cost reporting periods beginning on or after October 1, 2001.

Subtitle C—PPS-Exempt Hospitals

SEC. 121. WAGE ADJUSTMENT OF PERCENTILE CAP FOR PPS-EXEMPT HOSPITALS.

(a) IN GENERAL.—Section 1886(b)(3)(H) (42 U.S.C. 1395ww(b)(3)(H)) is amended—

(1) in clause (i), by inserting '', as adjusted under clause (iii)'' before the period;

(2) in clause (ii), by striking ''clause (i)'' and ''such clause'' and inserting ''subclause (I)'' and ''such subclause'' respectively;

(3) by striking ''(H)(i)'' and inserting ''(ii)(I)'';

(4) by redesignating clauses (ii) and (iii) as subclauses (II) and (III);

(5) by inserting after clause (ii), as so redesignated, the following new clause:

''(iii) In applying clause (ii)(I) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.''; and

(6) by inserting before clause (ii), as so redesignated, the following new clause:

''(H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv), for a cost reporting period beginning during fiscal years 1998 through 2002, the target amount for such a hospital or unit may not exceed the amount as updated up to or for such cost reporting period under clause (ii).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to cost reporting periods beginning on or after October 1, 1999.

SEC. 122. ENHANCED PAYMENTS FOR LONG-TERM CARE AND PSYCHIATRIC HOSPITALS UNTIL DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEMS FOR THOSE HOSPITALS.

Section 1886(b)(2) (42 U.S.C. 1395ww(b)(2)) is amended—

(1) in subparagraph (A), by striking ''In addition to'' and inserting ''Except as provided in subparagraph (E), in addition to''; and

(2) by adding at the end the following new subparagraph:

''(E)(i) In the case of an eligible hospital that is a hospital or unit that is within a class of hospital described in clause (ii) with a 12-month cost reporting period beginning before the enactment of this subparagraph, in determining the amount of the increase under subparagraph (A), the Secretary shall substitute for the percentage of the target amount applicable under subparagraph (A)(ii)—

''(I) for a cost reporting period beginning on or after October 1, 2000, and before September 30, 2001, 1.5 percent; and

''(II) for a cost reporting period beginning on or after October 1, 2001, and before September 30, 2002, 2 percent.

''(ii) For purposes of clause (i), each of the following shall be treated as a separate class of hospital:

''(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

''(II) Hospitals described in clause (iv) of such subsection.''.

SEC. 123. PER DISCHARGE PROSPECTIVE PAYMENT SYSTEM FOR LONG-TERM CARE HOSPITALS.

(a) DEVELOPMENT OF SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a per discharge prospective payment system for payment for inpatient hospital services of long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program. Such system shall include an adequate patient classification system that is based on diagnosis-related groups (DRGs) and that reflects

the differences in patient resource use and costs, and shall maintain budget neutrality.

(2) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such long-term care hospitals to submit such information to the Secretary as the Secretary may require to develop the system.

(b) REPORT.—Not later than October 1, 2001, the Secretary shall submit to the appropriate committees of Congress a report that includes a description of the system developed under subsection (a)(1).

(c) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Notwithstanding section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2002, for payments for inpatient hospital services furnished by long-term care hospitals under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the system described in subsection (a).

SEC. 124. PER DIEM PROSPECTIVE PAYMENT SYSTEM FOR PSYCHIATRIC HOSPITALS.

(a) DEVELOPMENT OF SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a per diem prospective payment system for payment for inpatient hospital services of psychiatric hospitals and units (as defined in paragraph (3)) under the medicare program. Such system shall include an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals and shall maintain budget neutrality.

(2) COLLECTION OF DATA AND EVALUATION.—In developing the system described in paragraph (1), the Secretary may require such psychiatric hospitals and units to submit such information to the Secretary as the Secretary may require to develop the system.

(3) DEFINITION.—In this section, the term ''psychiatric hospitals and units'' means a psychiatric hospital described in clause (i) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) and psychiatric units described in the matter following clause (v) of such section.

(b) REPORT.—Not later than October 1, 2001, the Secretary shall submit to the appropriate committees of Congress a report that includes a description of the system developed under subsection (a)(1).

(c) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Notwithstanding section 1886(b)(3) of the Social Security Act (42 U.S.C. 1395ww(b)(3)), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2002, for payments for inpatient hospital services furnished by psychiatric hospitals and units under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) in accordance with the prospective payment system established by the Secretary under this section in a budget neutral manner.

SEC. 125. REFINEMENT OF PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT REHABILITATION SERVICES.

(a) USE OF DISCHARGE AS PAYMENT UNIT.—

(1) IN GENERAL.—Section 1886(j)(1)(D) (42 U.S.C. 1395ww(j)(1)(D)) is amended by striking '', day of inpatient hospital services, or other unit of payment defined by the Secretary''.

(2) CONFORMING AMENDMENT TO CLASSIFICATION.—Section 1886(j)(2)(A)(i) (42 U.S.C. 1395ww(j)(2)(A)(i)) is amended to read as follows:

''(i) classes of patient discharges of rehabilitation facilities by functional-related groups (each in this subsection referred to as a 'case mix group'), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups; and''.

(3) CONSTRUCTION RELATING TO TRANSFER AUTHORITY.—Section 1886(j)(1) (42 U.S.C. 1395ww(j)(1)) is amended by adding at the end the following new subparagraph:

''(E) CONSTRUCTION RELATING TO TRANSFER AUTHORITY.—Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.''.

(b) STUDY ON IMPACT OF IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of the impact on utilization and beneficiary access to services of the implementation of the medicare prospective payment system for inpatient hospital services or rehabilitation facilities under section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)).

(2) REPORT.—Not later than 3 years after the date such system is first implemented, the Secretary shall submit to Congress a report on such study.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) are effective as if included in the enactment of section 4421(a) of BBA.

Subtitle D—Hospice Care

SEC. 131. TEMPORARY INCREASE IN PAYMENT FOR HOSPICE CARE.

(a) INCREASE FOR FISCAL YEARS 2001 AND 2002.—For purposes of payments under section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) for hospice care furnished during fiscal years 2001 and 2002, the Secretary of Health and Human Services shall increase the payment rate in effect (but for this section) for—

(1) fiscal year 2001, by 0.5 percent, and

(2) fiscal year 2002, by 0.75 percent.

(b) ADDITIONAL PAYMENT NOT BUILT INTO THE BASE.—The Secretary of Health and Human Services shall not include any additional payment made under this subsection (a) in updating the payment rate, as increased by the applicable market basket percentage increase for the fiscal year involved under section 1814(i)(1)(C)(ii) of that Act (42 U.S.C. 1395f(i)(1)(C)(ii)).

SEC. 132. STUDY AND REPORT TO CONGRESS REGARDING MODIFICATION OF THE PAYMENT RATES FOR HOSPICE CARE.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and advisability of updating the payment rates and the cap amount determined with respect to a fiscal year under section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) for routine home care and other services included in hospice care. Such study shall examine the cost factors used to determine such rates and such amount and shall evaluate whether such factors should be modified, eliminated, or supplemented with additional cost factors.

(b) REPORT.—Not later than one year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a), together with any recommendations for legislation that the Comptroller General determines to be appropriate as a result of such study.

Subtitle E—Other Provisions

SEC. 141. MEDPAC STUDY ON MEDICARE PAYMENT FOR NONPHYSICIAN HEALTH PROFESSIONAL CLINICAL TRAINING IN HOSPITALS.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of medicare payment policy with respect to professional clinical training of different classes of nonphysician health care professionals (such as nurses, nurse practitioners, allied health professionals, physician assistants, and psychologists) and the basis for any differences in treatment among such classes.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit a report to Congress on the study conducted under subsection (a).

Subtitle F—Transitional Provisions

SEC. 151. EXCEPTION TO CMI QUALIFIER FOR ONE YEAR.

Notwithstanding any other provision of law, for purposes of fiscal year 2000, the Northwest Mississippi Regional Medical Center located in Clarksdale, Mississippi shall be deemed to have satisfied the case mix index criteria under section 1886(d)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(C)(ii)) for classification as a rural referral center.

SEC. 152. RECLASSIFICATION OF CERTAIN COUNTIES AND AREAS FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

(a) FISCAL YEAR 2000.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal year 2000, for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))—

(1) to hospitals in Iredell County, North Carolina, such county is deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina Metropolitan Statistical Area;

(2) to hospitals in Orange County, New York, the large urban area of New York, New York is deemed to include such county;

(3) to hospitals in Lake County, Indiana, and to hospitals in Lee County, Illinois, such counties are deemed to be located in the Chicago, Illinois Metropolitan Statistical Area;

(4) to hospitals in Hamilton-Middletown, Ohio, Hamilton-Middletown, Ohio, is deemed to be located in the Cincinnati, Ohio-Kentucky-Indiana Metropolitan Statistical Area;

(5) to hospitals in Brazoria County, Texas, such county is deemed to be located in the Houston, Texas Metropolitan Statistical Area; and

(6) to hospitals in Chittenden County, Vermont, such county is deemed to be located in the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire Metropolitan Statistical Area.

(b) FISCAL YEAR 2001.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal year 2001, for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))—

(1) Iredell County, North Carolina is deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina Metropolitan Statistical Area;

(2) the large urban area of New York, New York is deemed to include Orange County, New York;

(3) Lake County, Indiana, and Lee County, Illinois, are deemed to be located in the Chicago, Illinois Metropolitan Statistical Area;

(4) Hamilton-Middletown, Ohio, is deemed to be located in the Cincinnati, Ohio-Kentucky-Indiana Metropolitan Statistical Area;

(5) Brazoria County, Texas, is deemed to be located in the Houston, Texas Metropolitan Statistical Area; and

(6) Chittenden County, Vermont is deemed to be located in the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire Metropolitan Statistical Area.

For purposes of that section, any reclassification under this subsection shall be treated as a decision of the Medicare Geographic Classification Review Board under paragraph (10) of that section.

SEC. 153. WAGE INDEX CORRECTION.

Notwithstanding any other provision of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the Secretary of Health and Human Services shall calculate and apply the Hattiesburg, Mississippi Metropolitan Statistical Area wage index under that section for discharges occurring during fiscal year 2000 using fiscal year 1996 wage and hour data for Wesley Medical Center for purposes of payment under that section for that fiscal year. Such recalculation shall not affect the wage index for any other area.

SEC. 154. CALCULATION AND APPLICATION OF WAGE INDEX FLOOR FOR A CERTAIN AREA.

(a) FISCAL YEAR 2000.—Notwithstanding any other provision of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), for discharges occurring during fiscal year 2000, the Secretary of Health and Human Services shall calculate and apply the wage index for the Allentown-Bethlehem-Easton Metropolitan Statistical Area under that section as if the Lehigh Valley Hospital were classified in such area for purposes of payment under that section for such fiscal year. Such recalculation shall not affect the wage index for any other area.

(b) FISCAL YEAR 2001.—Notwithstanding any other provision of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), in calculating and applying the wage indices under that section for discharges occurring during fiscal year 2001, Lehigh Valley Hospital shall be treated as being classified in the Allentown-Bethlehem-Easton Metropolitan Statistical Area.

SEC. 155. SPECIAL RULE FOR CERTAIN SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Notwithstanding any provision of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)), for the cost reporting period beginning in fiscal year 2000 and for the cost reporting period beginning in fiscal year 2001, if a skilled nursing facility which meets the criteria described in subsection (b) elects to be paid in accordance with subsection (c), the Secretary of Health and Human Services shall establish a per diem payment amount for such facility according to the methodology described in subsection (c) for such cost reporting periods in lieu of the payment amount that would otherwise be established for such facility under section 1888(e)(1) of such Act (42 U.S.C. 1395yy(e)(1)).

(b) FACILITY ELIGIBILITY CRITERIA.—For purposes of this subsection, a skilled nursing facility is one—

(1) that began participation in the Medicare program under title XVIII of the Social Security Act before January 1, 1995;

(2) for which at least 80 percent of the total inpatient days of the facility in the cost reporting period beginning in fiscal year 1998 were comprised of individuals entitled to benefits under such title; and

(3) that is located in Baldwin or Mobile County, Alabama.

(c) DETERMINATION OF PER DIEM AMOUNT.—For purposes of subsection (a), the per diem payment amount shall be equal to 100 percent of the amount determined under section 1888(e)(3) of the Social Security Act (42 U.S.C. 1395yy(e)(3)) except that, in determining such amount, the Secretary shall—

(1) substitute the allowable costs of the facility for the cost reporting period beginning in fiscal year 1998 for those allowable costs of the cost reporting period beginning in fiscal year 1995; and

(2) exclude the update to the first cost reporting period (from fiscal year 1995 to fiscal year 1998) described in section 1888(e)(3)(B)(i) of such Act (42 U.S.C. 1395yy(e)(3)(B)(i)).

TITLE II—PROVISIONS RELATING TO PART B

Subtitle A—Hospital Outpatient Services

SEC. 201. OUTLIER ADJUSTMENT AND TRANSITIONAL PASS-THROUGH FOR CERTAIN MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.

(a) OUTLIER ADJUSTMENT.—Section 1833(t) (42 U.S.C. 1395l(t)) is amended—

(1) by redesignating paragraphs (5) through (9) as paragraphs (7) through (11), respectively; and

(2) by inserting after paragraph (4) the following new paragraph:

''(5) OUTLIER ADJUSTMENT.—

''(A) IN GENERAL.—Subject to subparagraph (D), the Secretary shall provide for an additional payment for each covered OPD service (or group of services) for which a hospital's charges, adjusted to cost, exceed—

''(i) a fixed multiple of the sum of—

''(I) the applicable medicare OPD fee schedule amount determined under paragraph (3)(D), as adjusted under paragraph (4)(A) (other than for adjustments under this paragraph or paragraph (6)); and

''(II) any transitional pass-through payment under paragraph (6); and

''(ii) at the option of the Secretary, such fixed dollar amount as the Secretary may establish.

''(B) AMOUNT OF ADJUSTMENT.—The amount of the additional payment under subparagraph (A) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the applicable cutoff point under such subparagraph.

''(C) LIMIT ON AGGREGATE OUTLIER ADJUSTMENTS.—

''(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

''(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term 'applicable percentage' means a percentage specified by the Secretary up to (but not to exceed)—

''(I) for a year (or portion of a year) before 2004, 2.5 percent; and

''(II) for 2004 and thereafter, 3.0 percent.

''(D) TRANSITIONAL AUTHORITY.—In applying subparagraph (A) for covered OPD services furnished before January 1, 2002, the Secretary may—

''(i) apply such subparagraph to a bill for such services related to an outpatient encounter (rather than for a specific service or group of services) using OPD fee schedule amounts and transitional pass-through payments covered under the bill; and

''(ii) use an appropriate cost-to-charge ratio for the hospital involved (as determined by the Secretary), rather than for specific departments within the hospital.''.

(b) TRANSITIONAL PASS-THROUGH FOR ADDITIONAL COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—Such section is further amended by inserting after paragraph (5) the following new paragraph:

''(6) TRANSITIONAL PASS-THROUGH FOR ADDITIONAL COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—

''(A) IN GENERAL.—The Secretary shall provide for an additional payment under this paragraph for any of the following that are provided as part of a covered OPD service (or group of services):

''(i) CURRENT ORPHAN DRUGS.—A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act if payment for the drug or biological as an outpatient hospital service under this part was being made on the first date that the system under this subsection is implemented.

''(ii) CURRENT CANCER THERAPY DRUGS AND BIOLOGICALS AND BRACHYTHERAPY.—A drug or biological that is used in cancer therapy, including (but not limited to) a chemotherapeutic agent, an antiemetic, a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, a bisphosphonate, and a device of brachytherapy, if payment for such drug, biological, or device as an outpatient hospital service under this part was being made on such first date.

''(iii) CURRENT RADIOPHARMACEUTICAL DRUGS AND BIOLOGICAL PRODUCTS.—A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine procedures if payment for the drug or biological as an outpatient hospital service under this part was being made on such first date.

''(iv) NEW MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—A medical device, drug, or biological not described in clause (i), (ii), or (iii) if—

''(I) payment for the device, drug, or biological as an outpatient hospital service under this part was not being made as of December 31, 1996; and

''(II) the cost of the device, drug, or biological is not insignificant in relation to the OPD fee schedule amount (as calculated under paragraph (3)(D)) payable for the service (or group of services) involved.

''(B) LIMITED PERIOD OF PAYMENT.—The payment under this paragraph with respect to a medical device, drug, or biological shall only apply during a period of at least 2 years, but not more than 3 years, that begins—

''(i) on the first date this subsection is implemented in the case of a drug, biological, or device described in clause (i), (ii), or (iii) of subparagraph (A) and in the case of a device, drug, or biological described in subparagraph (A)(iv) and for which payment under this part is made as an outpatient hospital service before such first date; or

''(ii) in the case of a device, drug, or biological described in subparagraph (A)(iv) not described in clause (i), on the first date on which payment is made under this part for the device, drug, or biological as an outpatient hospital service.

''(C) AMOUNT OF ADDITIONAL PAYMENT.—Subject to subparagraph (D)(iii), the amount of the payment under this paragraph with respect to a device, drug, or biological provided as part of a covered OPD service is—

''(i) in the case of a drug or biological, the amount by which the amount determined under section 1842(o) for the drug or biological exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the drug or biological; or

''(ii) in the case of a medical device, the amount by which the hospital's charges for the device, adjusted to cost, exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the device.

''(D) LIMIT ON AGGREGATE ANNUAL ADJUSTMENT.—

''(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

''(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term 'applicable percentage' means—

''(I) for a year (or portion of a year) before 2004, 2.5 percent; and

''(II) for 2004 and thereafter, a percentage specified by the Secretary up to (but not to exceed) 2.0 percent.

''(iii) UNIFORM PROSPECTIVE REDUCTION IF AGGREGATE LIMIT PROJECTED TO BE EXCEEDED.—If the Secretary estimates before the beginning of a year that the amount of the additional payments under this paragraph for the year (or portion thereof) as determined under clause (i) without regard to this clause will exceed the limit established under such clause, the Secretary shall reduce pro rata the amount of each of the additional payments under this paragraph for that year (or portion thereof) in order

to ensure that the aggregate additional payments under this paragraph (as so estimated) do not exceed such limit.''.

(c) APPLICATION OF NEW ADJUSTMENTS ON A BUDGET NEUTRAL BASIS.—Section 1833(t)(2)(E) (42 U.S.C. 1395l(t)(2)(E)) is amended by striking ''other adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable payments, such as outlier adjustments or'' and inserting '', in a budget neutral manner, outlier adjustments under paragraph (5) and transitional pass-through payments under paragraph (6) and other adjustments as determined to be necessary to ensure equitable payments, such as''.

(d) LIMITATION ON JUDICIAL REVIEW FOR NEW ADJUSTMENTS.—Section 1833(t)(11), as redesignated by subsection (a)(1), is amended—

(1) by striking ''and'' at the end of subparagraph (C);

(2) by striking the period at the end of subparagraph (D) and inserting ''; and''; and

(3) by adding at the end the following:

''(E) the determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under paragraph (5) or the determination of insignificance of cost, the duration of the additional payments (consistent with paragraph (6)(B)), the portion of the medicare OPD fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under paragraph (6).''.

(e) INCLUSION OF CERTAIN IMPLANTABLE ITEMS UNDER SYSTEM.—

(1) IN GENERAL.—Section 1833(t) (42 U.S.C. 1395l(t)) is amended—

(A) in paragraph (1)(B)(ii), by striking ''clause (iii)'' and inserting ''clause (iv)'' and by striking ''but'';

(B) by redesignating clause (iii) of paragraph (1)(B) as clause (iv) and inserting after clause (ii) of such paragraph the following new clause:

''(iii) includes implantable items described in paragraph (3), (6), or (8) of section 1861(s); but''; and

(C) in paragraph (2)(B), by inserting after ''resources'' the following: ''and so that an implantable item is classified to the group that includes the service to which the item relates''.

(2) CONFORMING AMENDMENT.—(A) Section 1834(a)(13) (42 U.S.C. 1395m(a)(13)) is amended by striking ''1861(m)(5))'' and inserting ''1861(m)(5), but not including implantable items for which payment may be made under section 1833(t)''.

(B) Section 1834(h)(4)(B) (42 U.S.C. 1395m(h)(4)(B)) is amended by inserting before the semicolon the following: ''and does not include an implantable item for which payment may be made under section 1833(t)''.

(f) AUTHORIZING PAYMENT WEIGHTS BASED ON MEAN HOSPITAL COSTS.—Section 1833(t)(2)(C) (42 U.S.C. 1395l(t)(2)(C)) is amended by inserting ''(or, at the election of the Secretary, mean)'' after ''median''.

(g) LIMITING VARIATION OF COSTS OF SERVICES CLASSIFIED WITH A GROUP.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2)) is amended by adding at the end the following new flush sentence:

''For purposes of subparagraph (B), items and services within a group shall not be treated as 'comparable with respect to the use of resources' if the highest median cost (or mean cost, if elected by the Secretary under subparagraph (C)) for an item or service within the group is more than 2 times greater than the lowest median cost (or mean cost, if so elected) for an item or service within the group; except that the Secretary may make exceptions in unusual cases, such as low volume items and services, but may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act.''.

(h) ANNUAL REVIEW OF OPD PPS COMPONENTS.—

(1) IN GENERAL.—Section 1833(t)(8)(A) (42 U.S.C. 1395l(t)(8)(A)), as redesignated by subsection (a), is amended—

(A) by striking ''may periodically review'' and inserting ''shall review not less often than annually''; and

(B) by adding at the end the following: ''The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the groups and weights. Such panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting such review.''.

(2) EFFECTIVE DATES.—The Secretary of Health and Human Services shall first conduct the annual review under the amendment made by paragraph (1)(A) in 2001 for application in 2002 and the amendment made by paragraph (1)(B) takes effect on the date of the enactment of this Act.

(i) NO IMPACT ON COPAYMENT.—Section 1833(t)(7) (42 U.S.C. 1395l(t)(7)), as redesignated by subsection (a), is amended by adding at the end the following new subparagraph:

''(D) COMPUTATION IGNORING OUTLIER AND PASS-THROUGH ADJUSTMENTS.—The copayment amount shall be computed under subparagraph (A) as if the adjustments under paragraphs (5) and (6) (and any adjustment made under paragraph (2)(E) in relation to such adjustments) had not occurred.''.

(j) TECHNICAL CORRECTION IN REFERENCE RELATING TO HOSPITAL-BASED AMBULANCE SERVICES.—Section 1833(t)(9) (42 U.S.C. 1395l(t)(9)), as redesignated by subsection (a), is amended by striking ''the matter in subsection (a)(1) preceding subparagraph (A)'' and inserting ''section 1861(v)(1)(U)''.

(k) EXTENSION OF PAYMENT PROVISIONS OF SECTION 4522 OF BBA UNTIL IMPLEMENTATION OF PPS.—Section 1861(v)(1)(S)(ii) (42 U.S.C. 1395x(v)(1)(S)(ii)) is amended in subclauses (I) and (II) by striking ''and during fiscal year 2000 before January 1, 2000'' and inserting ''and until the first date that the prospective payment system under section 1833(t) is implemented'' each place it appears.

(l) CONGRESSIONAL INTENTION REGARDING BASE AMOUNTS IN APPLYING THE HOPD PPS.—With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of section 1833(t) of the Social Security Act, as added by section 4523(a) of BBA, Congress finds that such amount should be determined without regard to such section, in a budget neutral manner with respect to aggregate payments to hospitals, and that the Secretary of Health and Human Services has the authority to determine such amount without regard to such section.

(m) EFFECTIVE DATE.—Except as provided in this section, the amendments made by this section shall be effective as if included in the enactment of BBA.

(n) STUDY OF DELIVERY OF INTRAVENOUS IMMUNE GLOBULIN (IVIG) OUTSIDE HOSPITALS AND PHYSICIANS' OFFICES.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of the extent to which intravenous immune globulin (IVIG) could be delivered and reimbursed under the medicare program outside of a hospital or physician's office. In conducting the study, the Secretary shall—

(A) consider the sites of service that other payors, including Medicare+Choice plans, use for these drugs and biologicals;

(B) determine whether covering the delivery of these drugs and biologicals in a medicare patient's home raises any additional safety and health concerns for the patient;

(C) determine whether covering the delivery of these drugs and biologicals in a patient's home can reduce overall spending under the medicare program; and

(D) determine whether changing the site of setting for these services would affect beneficiary access to care.

(2) REPORT.—The Secretary shall submit a report on such study to the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate within 18 months after the date of the enactment of this Act. The Secretary shall include in the report recommendations regarding the appropriate manner and settings under which the medicare program should pay for these drugs and biologicals delivered outside of a hospital or physician's office.

SEC. 202. ESTABLISHING A TRANSITIONAL CORRIDOR FOR APPLICATION OF OPD PPS.

(a) IN GENERAL.—Section 1833(t) (42 U.S.C. 1395l(t)), as amended by section 201(a), is further amended—

(1) in paragraph (4), in the matter before subparagraph (A), by inserting '', subject to paragraph (7),'' after ''is determined''; and

(2) by redesignating paragraphs (7) through (11) as paragraphs (8) through (12), respectively; and

(3) by inserting after paragraph (6), as inserted by section 201(b), the following new paragraph:

''(7) TRANSITIONAL ADJUSTMENT TO LIMIT DECLINE IN PAYMENT.—

''(A) BEFORE 2002.—Subject to subparagraph (D), for covered OPD services furnished before January 1, 2002, for which the PPS amount (as defined in subparagraph (E)) is—

''(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount (as defined in subparagraph (F)), the amount of payment under this subsection shall be increased by 80 percent of the amount of such difference;

''(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.71 and the pre-BBA amount, exceeds (II) the product of 0.70 and the PPS amount;

''(iii) at least 70 percent, but less than 80 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.63 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount; or

''(iv) less than 70 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 21 percent of the pre-BBA amount.

''(B) 2002.—Subject to subparagraph (D), for covered OPD services furnished during 2002, for which the PPS amount is—

''(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 70 percent of the amount of such difference;

''(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.61 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount; or

''(iii) less than 80 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 13 percent of the pre-BBA amount.

''(C) 2003.—Subject to subparagraph (D), for covered OPD services furnished during 2003, for which the PPS amount is—

''(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 60 percent of the amount of such difference; or

''(ii) less than 90 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 6 percent of the pre-BBA amount.

''(D) HOLD HARMLESS PROVISIONS.—

''(i) TEMPORARY TREATMENT FOR SMALL RURAL HOSPITALS.—In the case of a hospital located in a rural area and that has not more than 100 beds, for covered OPD services furnished before January 1, 2004, for which the PPS amount is less than the pre-BBA amount, the amount of

payment under this subsection shall be increased by the amount of such difference.

''(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(v), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

''(E) PPS AMOUNT DEFINED.—In this paragraph, the term 'PPS amount' means, with respect to covered OPD services, the amount payable under this title for such services (determined without regard to this paragraph), including amounts payable as copayment under paragraph (8), coinsurance under section 1866(a)(2)(A)(ii), and the deductible under section 1833(b).

''(F) PRE-BBA AMOUNT DEFINED.—

''(i) IN GENERAL.—In this paragraph, the 'pre-BBA amount' means, with respect to covered OPD services furnished by a hospital in a year, an amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital's cost reporting period (or periods) occurring in the year and the base OPD payment-to-cost ratio for the hospital (as defined in clause (ii)).

''(ii) BASE PAYMENT-TO-COST-RATIO DEFINED.—For purposes of this subparagraph, the 'base payment-to-cost ratio' for a hospital means the ratio of—

''(I) the hospital's reimbursement under this part for covered OPD services furnished during the cost reporting period ending in 1996, including any reimbursement for such services through cost-sharing described in subparagraph (E), to

''(II) the reasonable cost of such services for such period.

The Secretary shall determine such ratios as if the amendments made by section 4521 of the Balanced Budget Act of 1997 were in effect in 1996.

''(G) INTERIM PAYMENTS.—The Secretary shall make payments under this paragraph to hospitals on an interim basis, subject to retrospective adjustments based on settled cost reports.

''(H) NO EFFECT ON COPAYMENTS.—Nothing in this paragraph shall be construed to affect the unadjusted copayment amount described in paragraph (3)(B) or the copayment amount under paragraph (8).

''(I) APPLICATION WITHOUT REGARD TO BUDGET NEUTRALITY.—The additional payments made under this paragraph—

''(i) shall not be considered an adjustment under paragraph (2)(E); and

''(ii) shall not be implemented in a budget neutral manner.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of BBA.

SEC. 203. STUDY AND REPORT TO CONGRESS REGARDING THE SPECIAL TREATMENT OF RURAL AND CANCER HOSPITALS IN PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) STUDY.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission (referred to in this section as ''MedPAC'') shall conduct a study to determine the appropriateness (and the appropriate method) of providing payments to hospitals described in paragraph (2) for covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t))) based on the prospective payment system established by the Secretary in accordance with such section.

(2) HOSPITALS DESCRIBED.—The hospitals described in this paragraph are the following:

(A) A medicare-dependent, small rural hospital (as defined in section 1886(d)(5)(G)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)(iv))).

(B) A sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))).

(C) Rural health clinics (as defined in section 1861(aa)(2) of such Act (42 U.S.C. 1395x(aa)(2)).

(D) Rural referral centers (as so classified under section 1886(d)(5)(C) of such Act (42 U.S.C. 1395ww(d)(5)(C)).

(E) Any other rural hospital with not more than 100 beds.

(F) Any other rural hospital that the Secretary determines appropriate.

(G) A hospital described in section 1886(d)(1)(B)(v) of such Act (42 U.S.C. 1395ww(d)(1)(B)(v)).

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, MedPAC shall submit a report to the Secretary of Health and Human Services and Congress on the study conducted under subsection (a), together with any recommendations for legislation that MedPAC determines to be appropriate as a result of such study.

(c) COMMENTS.—Not later than 60 days after the date on which MedPAC submits the report under subsection (b) to the Secretary of Health and Human Services, the Secretary shall submit comments on such report to Congress.

SEC. 204. LIMITATION ON OUTPATIENT HOSPITAL COPAYMENT FOR A PROCEDURE TO THE HOSPITAL DEDUCTIBLE AMOUNT.

(a) IN GENERAL.—Section 1833(t)(8) (42 U.S.C. 1395l(t)(8)), as redesignated by sections 201(a)(1) and 202(a)(2), is amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)'';

(2) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively; and

(3) by inserting after subparagraph (B) the following new subparagraph:

''(C) LIMITING COPAYMENT AMOUNT TO INPATIENT HOSPITAL DEDUCTIBLE AMOUNT.—In no case shall the copayment amount for a procedure performed in a year exceed the amount of the inpatient hospital deductible established under section 1813(b) for that year.''.

(b) INCREASE IN PAYMENT TO REFLECT REDUCTION IN COPAYMENT.—Section 1833(t)(4)(C) (42 U.S.C. 1395l(t)(4)(C)) is amended by inserting '', plus the amount of any reduction in the copayment amount attributable to paragraph (8)(C)'' before the period at the end.

(c) EFFECTIVE DATE.—The amendments made by this section apply as if included in the enactment of BBA and shall only apply to procedures performed for which payment is made on the basis of the prospective payment system under section 1833(t) of the Social Security Act.

Subtitle B—Physician Services

SEC. 211. MODIFICATION OF UPDATE ADJUSTMENT FACTOR PROVISIONS TO REDUCE UPDATE OSCILLATIONS AND REQUIRE ESTIMATE REVISIONS.

(a) UPDATE ADJUSTMENT FACTOR.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended—

(A) in paragraph (3)—

(i) in the heading, by inserting ''FOR 1999 AND 2000'' after ''UPDATE'';

(ii) in subparagraph (A), by striking ''a year beginning with 1999'' and inserting ''1999 and 2000''; and

(iii) in subparagraph (C), by inserting ''and paragraph (4)'' after ''For purposes of this paragraph''; and

(B) by adding at the end the following new paragraph:

''(4) UPDATE FOR YEARS BEGINNING WITH 2001.—

''(A) IN GENERAL.—Unless otherwise provided by law, subject to the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii) and subject to adjustment under subparagraph (F), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 2001 is equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100); and

''(ii) 1 plus the Secretary's estimate of the update adjustment factor under subparagraph (B) for the year.

''(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), subject to subparagraph (D), the 'update adjustment factor' for a year is equal (as estimated by the Secretary) to the sum of the following:

''(i) PRIOR YEAR ADJUSTMENT COMPONENT.—An amount determined by—

''(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (as determined under subparagraph (C)) and the amount of the actual expenditures for such services for that year;

''(II) dividing that difference by the amount of the actual expenditures for such services for that year; and

''(III) multiplying that quotient by 0.75.

''(ii) CUMULATIVE ADJUSTMENT COMPONENT.—An amount determined by—

''(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services (as determined under subparagraph (C)) from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for such services during that period;

''(II) dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate under subsection (f) for the year for which the update adjustment factor is to be determined; and

''(III) multiplying that quotient by 0.33.

''(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph:

''(i) PERIOD UP TO APRIL 1, 1999.—The allowed expenditures for physicians' services for a period before April 1, 1999, shall be the amount of the allowed expenditures for such period as determined under paragraph (3)(C).

''(ii) TRANSITION TO CALENDAR YEAR ALLOWED EXPENDITURES.—Subject to subparagraph (E), the allowed expenditures for—

''(I) the 9-month period beginning April 1, 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such period; and

''(II) the year of 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such year.

''(iii) YEARS BEGINNING WITH 2000.—The allowed expenditures for a year (beginning with 2000) is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the year involved.

''(D) RESTRICTION ON UPDATE ADJUSTMENT FACTOR.—The update adjustment factor determined under subparagraph (B) for a year may not be less than −0.07 or greater than 0.03.

''(E) RECALCULATION OF ALLOWED EXPENDITURES FOR UPDATES BEGINNING WITH 2001.—For purposes of determining the update adjustment factor for a year beginning with 2001, the Secretary shall recompute the allowed expenditures for previous periods beginning on or after April 1, 1999, consistent with subsection (f)(3).

''(F) TRANSITIONAL ADJUSTMENT DESIGNED TO PROVIDE FOR BUDGET NEUTRALITY.—Under this subparagraph the Secretary shall provide for an adjustment to the update under subparagraph (A)—

''(i) for each of 2001, 2002, 2003, and 2004, of −0.2 percent; and

''(ii) for 2005 of +0.8 percent.''.

(2) PUBLICATION CHANGE.—

(A) IN GENERAL.—Section 1848(d)(1)(E) (42 U.S.C. 1395w–4(d)(1)(E)) is amended to read as follows:

''(E) PUBLICATION AND DISSEMINATION OF INFORMATION.—The Secretary shall—

''(i) cause to have published in the Federal Register not later than November 1 of each year (beginning with 2000) the conversion factor

which will apply to physicians' services for the succeeding year, the update determined under paragraph (4) for such succeeding year, and the allowed expenditures under such paragraph for such succeeding year; and

''(ii) make available to the Medicare Payment Advisory Commission and the public by March 1 of each year (beginning with 2000) an estimate of the sustainable growth rate and of the conversion factor which will apply to physicians' services for the succeeding year and data used in making such estimate.''.

(B) MEDPAC REVIEW OF CONVERSION FACTOR ESTIMATES.—Section 1805(b)(1)(D) (42 U.S.C. 1395b–6(b)(1)(D)) is amended by inserting ''and including a review of the estimate of the conversion factor submitted under section 1848(d)(1)(E)(ii)'' before the period at the end.

(C) ONE-TIME PUBLICATION OF INFORMATION ON TRANSITION.—The Secretary of Health and Human Services shall cause to have published in the Federal Register, not later than 90 days after the date of the enactment of this section, the Secretary's determination, based upon the best available data, of—

(i) the allowed expenditures under subclauses (I) and (II) of subsection (d)(4)(C)(ii) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by subsection (a)(1)(B), for the 9-month period beginning on April 1, 1999, and for 1999;

(ii) the estimated actual expenditures described in subsection (d) of such section for 1999; and

(iii) the sustainable growth rate under subsection (f) of such section for 2000.

(3) CONFORMING AMENDMENTS.—

(A) Section 1848 (42 U.S.C. 1395w–4) is amended—

(i) in subsection (d)(1)(A), by inserting ''(for years before 2001) and, for years beginning with 2001, multiplied by the update (established under paragraph (4)) for the year involved'' after ''for the year involved''; and

(ii) in subsection (f)(2)(D), by inserting ''or (d)(4)(B), as the case may be'' after ''(d)(3)(B)''.

(B) Section 1833(l)(4)(A)(i)(VII) (42 U.S.C. 1395l(l)(4)(A)(i)(VII)) is amended by striking ''1848(d)(3)'' and inserting ''1848(d)''.

(b) SUSTAINABLE GROWTH RATES.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended—

(1) by amending paragraph (1) to read as follows:

''(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register not later than—

''(A) November 1, 2000, the sustainable growth rate for 2000 and 2001; and

''(B) November 1 of each succeeding year the sustainable growth rate for such succeeding year and each of the preceding 2 years.'';

(2) in paragraph (2)—

(A) in the matter before subparagraph (A), by striking ''fiscal year 1998)'' and inserting ''fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000''; and

(B) in subparagraphs (A) through (D), by striking ''fiscal year'' and inserting ''applicable period'' each place it appears;

(3) in paragraph (3), by adding at the end the following new subparagraph:

''(C) APPLICABLE PERIOD.—The term 'applicable period' means—

''(i) a fiscal year, in the case of fiscal year 1998, fiscal year 1999, and fiscal year 2000; or

''(ii) a calendar year with respect to a year beginning with 2000;

as the case may be.'';

(4) by redesignating paragraph (3) as paragraph (4); and

(5) by inserting after paragraph (2) the following new paragraph:

''(3) DATA TO BE USED.—For purposes of determining the update adjustment factor under subsection (d)(4)(B) for a year beginning with 2001, the sustainable growth rates taken into consideration in the determination under paragraph (2) shall be determined as follows:

''(A) FOR 2001.—For purposes of such calculations for 2001, the sustainable growth rates for fiscal year 2000 and the years 2000 and 2001 shall be determined on the basis of the best data available to the Secretary as of September 1, 2000.

''(B) FOR 2002.—For purposes of such calculations for 2002, the sustainable growth rates for fiscal year 2000 and for years 2000, 2001, and 2002 shall be determined on the basis of the best data available to the Secretary as of September 1, 2001.

''(C) FOR 2003 AND SUCCEEDING YEARS.—For purposes of such calculations for a year after 2002—

''(i) the sustainable growth rates for that year and the preceding 2 years shall be determined on the basis of the best data available to the Secretary as of September 1 of the year preceding the year for which the calculation is made; and

''(ii) the sustainable growth rate for any year before a year described in clause (i) shall be the rate as most recently determined for that year under this subsection.

Nothing in this paragraph shall be construed as affecting the sustainable growth rates established for fiscal year 1998 or fiscal year 1999.''.

(c) STUDY AND REPORT REGARDING THE UTILIZATION OF PHYSICIANS' SERVICES BY MEDICARE BENEFICIARIES.—

(1) STUDY BY SECRETARY.—The Secretary of Health and Human Services, acting through the Administrator of the Agency for Health Care Policy and Research, shall conduct a study of the issues specified in paragraph (2).

(2) ISSUES TO BE STUDIED.—The issues specified in this paragraph are the following:

(A) The various methods for accurately estimating the economic impact on expenditures for physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) resulting from—

(i) improvements in medical capabilities;

(ii) advancements in scientific technology;

(iii) demographic changes in the types of medicare beneficiaries that receive benefits under such program; and

(iv) geographic changes in locations where medicare beneficiaries receive benefits under such program.

(B) The rate of usage of physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) among beneficiaries between ages 65 and 74, 75 and 84, 85 and over, and disabled beneficiaries under age 65.

(C) Other factors that may be reliable predictors of beneficiary utilization of physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(3) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress setting forth the results of the study conducted pursuant to paragraph (1), together with any recommendations the Secretary determines are appropriate.

(4) MEDPAC REPORT TO CONGRESS.—Not later than 180 days after the date of submission of the report under paragraph (3), the Medicare Payment Advisory Commission shall submit a report to Congress that includes—

(A) an analysis and evaluation of the report submitted under paragraph (3); and

(B) such recommendations as it determines are appropriate.

(d) EFFECTIVE DATE.—The amendments made by this section shall be effective in determining the conversion factor under section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) for years beginning with 2001 and shall not apply to or affect any update (or any update adjustment factor) for any year before 2001.

SEC. 212. USE OF DATA COLLECTED BY ORGANIZATIONS AND ENTITIES IN DETERMINING PRACTICE EXPENSE RELATIVE VALUES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish by regulation (after notice and opportunity for public comment) a process (including data collection standards) under which the Secretary will accept for use and will use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations (other than the Department of Health and Human Services) to supplement the data normally collected by that Department in determining the practice expense component under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)) for purposes of determining relative values for payment for physicians' services under the fee schedule under section 1848 of such Act (42 U.S.C. 1395w–4). The Secretary shall first promulgate such regulation on an interim final basis in a manner that permits the submission and use of data in the computation of practice expense relative value units for payment rates for 2001.

(b) PUBLICATION OF INFORMATION.—The Secretary shall include, in the publication of the estimated and final updates under section 1848(c) of such Act (42 U.S.C. 1395w–4(c)) for payments for 2001 and for 2002, a description of the process established under subsection (a) for the use of external data in making adjustments in relative value units and the extent to which the Secretary has used such external data in making such adjustments for each such year, particularly in cases in which the data otherwise used are inadequate because such data are not based upon a large enough sample size to be statistically reliable.

SEC. 213. GAO STUDY ON RESOURCES REQUIRED TO PROVIDE SAFE AND EFFECTIVE OUTPATIENT CANCER THERAPY.

(a) STUDY.—The Comptroller General of the United States shall conduct a nationwide study to determine the physician and non-physician clinical resources necessary to provide safe outpatient cancer therapy services and the appropriate payment rates for such services under the medicare program. In making such determination, the Comptroller General shall—

(1) determine the adequacy of practice expense relative value units associated with the utilization of those clinical resources;

(2) determine the adequacy of work units in the practice expense formula; and

(3) assess various standards to assure the provision of safe outpatient cancer therapy services.

(b) REPORT TO CONGRESS.—The Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding practice expense adjustments to the payment methodology under part B of title XVIII of the Social Security Act, including the development and inclusion of adequate work units to assure the adequacy of payment amounts for safe outpatient cancer therapy services. The study shall also include an estimate of the cost of implementing such recommendations.

Subtitle C—Other Services

SEC. 221. REVISION OF PROVISIONS RELATING TO THERAPY SERVICES.

(a) 2-YEAR MORATORIUM ON CAPS.—

(1) IN GENERAL.—Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended—

(A) in paragraphs (1) and (3), by striking ''In the case'' each place it appears and inserting ''Subject to paragraph (4), in the case''; and

(B) by adding at the end the following:

''(4) This subsection shall not apply to expenses incurred with respect to services furnished during 2000 and 2001.''.

(2) FOCUSED MEDICAL REVIEWS OF CLAIMS DURING MORATORIUM PERIOD.—During years in which paragraph (4) of section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) applies

(under the amendment made by paragraph (1)(B)), the Secretary of Health and Human Services shall conduct focused medical reviews of claims for reimbursement for services described in paragraph (1) or (3) of such section, with an emphasis on such claims for services that are provided to residents of skilled nursing facilities.

(b) TECHNICAL AMENDMENT RELATING TO BEING UNDER THE CARE OF A PHYSICIAN.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended—

(A) in subsection (p)(1), by striking ''or (3)'' and inserting '', (3), or (4)''; and

(B) in subsection (r)(4), by inserting ''for purposes of subsection (p)(1) and'' after ''but only''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) apply to services furnished on or after January 1, 2000.

(c) REVISION OF REPORT.—

(1) IN GENERAL.—Section 4541(d)(2) of BBA (42 U.S.C. 1395l note) is amended to read as follows:

''(2) REPORT.—Not later than January 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report that includes recommendations on—

''(A) the establishment of a mechanism for assuring appropriate utilization of outpatient physical therapy services, outpatient occupational therapy services, and speech-language pathology services that are covered under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395); and

''(B) the establishment of an alternative payment policy for such services based on classification of individuals by diagnostic category, functional status, prior use of services (in both inpatient and outpatient settings), and such other criteria as the Secretary determines appropriate, in place of the uniform dollar limitations specified in section 1833(g) of such Act, as amended by paragraph (1).

The recommendations shall include how such a mechanism or policy might be implemented in a budget-neutral manner.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of section 4541 of BBA.

(d) STUDY AND REPORT ON UTILIZATION.—

(1) STUDY.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study which compares—

(i) utilization patterns (including nationwide patterns, and patterns by region, types of settings, and diagnosis or condition) of outpatient physical therapy services, outpatient occupational therapy services, and speech-language pathology services that are covered under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395) and provided on or after January 1, 2000; with

(ii) such patterns for such services that were provided in 1998 and 1999.

(B) REVIEW OF CLAIMS.—In conducting the study under this subsection the Secretary of Health and Human Services shall review a statistically significant number of claims for reimbursement for the services described in subparagraph (A).

(2) REPORT.—Not later than June 30, 2001, the Secretary of Health and Human Services shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.

SEC. 222. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.

(a) IN GENERAL.—Section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by adding at the end the following new flush sentence:

''The Secretary shall increase the amount of each composite rate payment for dialysis services furnished during 2000 by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 1999, and for such services furnished on or after January 1, 2001, by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 2000.''.

(b) CONFORMING AMENDMENT.—The second sentence of section 9335(a)(1) of the Omnibus Budget Reconciliation Act of 1986 (42 U.S.C. 1395rr note) is amended by inserting ''and before January 1, 2000,'' after ''on or after January 1, 1991,''.

(c) STUDY ON PAYMENT LEVEL FOR HOME HEMODIALYSIS.—The Medicare Payment Advisory Commission shall conduct a study on the appropriateness of the differential in payment under the medicare program for hemodialysis services furnished in a facility and such services furnished in a home. Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on such study and shall include recommendations regarding changes in medicare payment policy in response to the study.

SEC. 223. IMPLEMENTATION OF THE INHERENT REASONABLENESS (IR) AUTHORITY.

(a) LIMITATION ON USE.—The Secretary of Health and Human Services may not use, or permit fiscal intermediaries or carriers to use, the inherent reasonableness authority provided under section 1842(b)(8) of the Social Security Act (42 U.S.C. 1395u(b)(8)) until after—

(1) the Comptroller General of the United States releases a report pursuant to the request for such a report made on March 1, 1999, regarding the impact of the Secretary's, fiscal intermediaries', and carriers' use of such authority; and

(2) the Secretary has published a notice of final rulemaking in the Federal Register that relates to such authority and that responds to such report and to comments received in response to the Secretary's interim final regulation relating to such authority that was published in the Federal Register on January 7, 1998.

(b) REEVALUATION OF IR CRITERIA.—In promulgating the final regulation under subsection (a)(2), the Secretary shall—

(1) reevaluate the appropriateness of the criteria included in such interim final regulation for identifying payments which are excessive or deficient; and

(2) take appropriate steps to ensure the use of valid and reliable data when exercising such authority.

(c) TECHNICAL CORRECTION.—Section 1842(b)(8)(A)(i)(1) (42 U.S.C. 1395u(b)(8)(A)(i)(I)) is amended by striking ''the application of this part'' and inserting ''the application of this title to payment under this part''.

SEC. 224. INCREASE IN REIMBURSEMENT FOR PAP SMEARS.

(a) PAP SMEAR PAYMENT INCREASE.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following new paragraph:

''(7) Notwithstanding paragraphs (1) and (4), the Secretary shall establish a national minimum payment amount under this subsection for a diagnostic or screening pap smear laboratory test (including all cervical cancer screening technologies that have been approved by the Food and Drug Administration as a primary screening method for detection of cervical cancer) equal to $14.60 for tests furnished in 2000. For such tests furnished in subsequent years, such national minimum payment amount shall be adjusted annually as provided in paragraph (2).''.

(b) SENSE OF CONGRESS.—It is the sense of the Congress that—

(1) the Health Care Financing Administration has been slow to incorporate or provide incentives for providers to use new screening diagnostic health care technologies in the area of cervical cancer;

(2) some new technologies have been developed which optimize the effectiveness of pap smear screening; and

(3) the Health Care Financing Administration should institute an appropriate increase in the payment rate for new cervical cancer screening technologies that have been approved by the Food and Drug Administration and that are significantly more effective than a conventional pap smear.

SEC. 225. REFINEMENT OF AMBULANCE SERVICES DEMONSTRATION PROJECT.

Effective as if included in the enactment of BBA, section 4532 of BBA (42 U.S.C. 1395m note) is amended—

(1) in subsection (a), by adding at the end the following: ''Not later than July 1, 2000, the Secretary shall publish a request for proposals for such projects.''; and

(2) by amending paragraph (2) of subsection (b) to read as follows:

''(2) CAPITATED PAYMENT RATE DEFINED.—In this subsection, the term 'capitated payment rate' means, with respect to a demonstration project—

''(A) in its first year, a rate established for the project by the Secretary, using the most current available data, in a manner that ensures that aggregate payments under the project will not exceed the aggregate payment that would have been made for ambulance services under part B of title XVIII of the Social Security Act in the local area of government's jurisdiction; and

''(B) in a subsequent year, the capitated payment rate established for the previous year increased by an appropriate inflation adjustment factor.''.

SEC. 226. PHASE-IN OF PPS FOR AMBULATORY SURGICAL CENTERS.

If the Secretary of Health and Human Services implements a revised prospective payment system for services of ambulatory surgical facilities under section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)), prior to incorporating data from the 1999 Medicare cost survey or a subsequent cost survey, such system shall be implemented in a manner so that—

(1) in the first year of its implementation, only a proportion (specified by the Secretary and not to exceed ⅓) of the payment for such services shall be made in accordance with such system and the remainder shall be made in accordance with current regulations; and

(2) in the following year a proportion (specified by the Secretary and not to exceed ⅔) of the payment for such services shall be made under such system and the remainder shall be made in accordance with current regulations.

SEC. 227. EXTENSION OF MEDICARE BENEFITS FOR IMMUNOSUPPRESSIVE DRUGS.

(a) IN GENERAL.—Section 1861(s)(2)(J)(v) (42 U.S.C. 1395x(s)(2)(J)(v)) is amended by inserting before the semicolon at the end the following: ''plus such additional number of months (if any) provided under section 1832(b)''.

(b) SPECIFICATION OF NUMBER OF ADDITIONAL MONTHS.—Section 1832 (42 U.S.C. 1395k) is amended—

(1) by redesignating subsection (b) as subsection (c); and

(2) by inserting after subsection (a) the following new subsection:

''(b) EXTENSION OF COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

''(1) EXTENSION.—

''(A) IN GENERAL.—The Secretary shall specify consistent with this subsection an additional number of months (which may be portions of months) of coverage of immunosuppressive drugs for each cohort (as defined in subparagraph (C)) in a year during the 5-year period beginning with 2000. The number of such months for the cohort—

''(i) for 2000 shall be 8 months; and

''(ii) for 2001 shall, subject to paragraph (2)(A)(i), be 8 months.

''(B) APPLICATION OF ADDITIONAL MONTHS IN A YEAR ONLY TO COHORT IN THAT YEAR.—

''(i) IN GENERAL.—The additional months specified under this subsection for a cohort in a year in such 5-year period shall apply under section 1861(s)(2)(J)(v) only to individuals within such cohort for such year.

''(ii) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing additional months of coverage provided for a cohort for a year from extending coverage to drugs furnished in months in the succeeding year.

''(C) COHORT DEFINED.—In this subsection, the term 'cohort' means, with respect to a year, those individuals who would (but for this subsection) exhaust benefits under section 1861(s)(2)(J)(v) for prescription drugs used in immunosuppressive therapy furnished at any time during such year.

''(2) TIMING OF SPECIFICATION.—Consistent with paragraphs (3) and (4)—

''(A) MAY 1, 2001.—Not later than May 1, 2001, the Secretary—

''(i) may increase the number of months for the cohort for 2001 above the 8 months provided under paragraph (1)(A)(ii); and

''(ii) shall compute and specify the number of additional months of benefits that will be available for the cohort for 2002.

''(B) MAY 1, 2002 AND 2003.—Not later than May 1 of 2002 and 2003, the Secretary shall compute and specify the number of additional months of benefits that will be available for the cohort for the following year under this subsection. Such number may be more or less than 8 months.

''(3) BASIS FOR SPECIFICATION.—Using appropriate actuarial methods, the Secretary shall compute the number of additional months for the cohort for a year under this subsection in a manner so that the total expenditures under this part attributable to this subsection, as computed based upon the best available data at the time additional months are specified under this subsection, do not exceed $150,000,000. Subject to paragraph (4), the Secretary shall seek to compute such months in a manner that provides for a level number of months for each cohort in each year in the last 4 years of the 5-year period described in paragraph (1)(A).

''(4) ANNUAL ADJUSTMENT TO MAINTAIN AGGREGATE EXPENDITURES WITHIN LIMITS.—In computing and specifying the number of additional months under paragraph (2), the Secretary shall adjust the number of additional months under this subsection for a cohort for a year from that provided in the previous year within such 5-year period to the extent necessary to take into account, based upon the best available data, differences between actual and estimated expenditures under this part attributable to this subsection for previous years and to comply with the limitation on total expenditures under paragraph (3).''.

(c) TRANSITIONAL PASS-THROUGH OF ADDITIONAL COSTS UNDER MEDICARE+CHOICE PROGRAM FOR 2000.—The provisions of subparagraphs (A) and (B) of section 1852(a)(5) of the Social Security Act (42 U.S.C. 1395w–22(a)(5)) shall apply with respect to the coverage of additional benefits for immunosuppressive drugs under the amendments made by this section for drugs furnished in 2000 in the same manner as if such amendments constituted a national coverage determination described in the matter in such section before subparagraph (A).

(d) REPORT ON IMMUNOSUPPRESSIVE DRUG BENEFIT.—

(1) IN GENERAL.—Not later than March 1, 2003, the Secretary of Health and Human Services shall submit to Congress a report on the operation of this section and the amendments made by this section. The report shall include—

(A) an analysis of the impact of this section; and

(B) recommendations regarding an appropriate cost-effective method for providing coverage of immunosuppressive drugs under the medicare program on a permanent basis.

(2) CONSIDERATIONS.—In making recommendations under paragraph (1)(B), the Secretary shall identify potential modifications to the immunosuppressive drug benefit that would best promote the objectives of—

(A) improving health outcomes (by decreasing transplant rejection rates that are attributable to failure to comply with immunosuppressive drug regimens);

(B) achieving cost savings to the medicare program (by decreasing the need for secondary transplants and other care relating to post-transplant complications); and

(C) meeting the needs of those medicare beneficiaries who, because of income or other factors, would be less likely to maintain an immunosuppressive drug regimen in the absence of such modifications.

SEC. 228. TEMPORARY INCREASE IN PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT AND OXYGEN.

(a) IN GENERAL.—For purposes of payments under section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) for covered items (as defined in paragraph (13) of that section) furnished during 2001 and 2002, the Secretary of Health and Human Services shall increase the payment amount in effect (but for this section) for such items for—

(1) 2001 by 0.3 percent, and

(2) 2002 by 0.6 percent.

(b) LIMITING APPLICATION TO SPECIFIED YEARS.—The payment amount increase—

(1) under subsection (a)(1) shall not apply after 2001 and shall not be taken into account in calculating the payment amounts applicable for covered items furnished after such year; and

(2) under subsection (a)(2) shall not apply after 2002 and shall not be taken into account in calculating the payment amounts applicable for covered items furnished after such year.

SEC. 229. STUDIES AND REPORTS.

(a) MEDPAC STUDY ON POSTSURGICAL RECOVERY CARE CENTER SERVICES.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study on the cost-effectiveness and efficacy of covering under the medicare program under title XVIII of the Social Security Act services of a post-surgical recovery care center (that provides an intermediate level of recovery care following surgery). In conducting such study, the Commission shall consider data on these centers gathered in demonstration projects.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Commission shall submit to Congress a report on such study and shall include in the report recommendations on the feasibility, costs, and savings of covering such services under the medicare program.

(b) AHCPR STUDY ON EFFECT OF CREDENTIALING OF TECHNOLOGISTS AND SONOGRAPHERS ON QUALITY OF ULTRASOUND.—

(1) STUDY.—The Administrator for Health Care Policy and Research shall provide for a study that, with respect to the provision of ultrasound under the medicare and medicaid programs under titles XVIII and XIX of the Social Security Act, compares differences in quality between ultrasound furnished by individuals who are credentialed by private entities or organizations and ultrasound furnished by those who are not so credentialed. Such study shall examine and evaluate differences in error rates, resulting complications, and patient outcomes as a result of the differences in credentialing. In designing the study, the Administrator shall consult with organizations nationally recognized for their expertise in ultrasound.

(2) REPORT.—Not later than two years after the date of the enactment of this Act, the Administrator shall submit a report to Congress on the study conducted under paragraph (1).

(c) MEDPAC STUDY ON THE COMPLEXITY OF THE MEDICARE PROGRAM AND THE LEVELS OF BURDENS PLACED ON PROVIDERS THROUGH FEDERAL REGULATIONS.—

(1) STUDY.—The Medicare Payment Advisory Commission shall undertake a comprehensive study to review the regulatory burdens placed on all classes of health care providers under parts A and B of the medicare program under title XVIII of the Social Security Act and to determine the costs these burdens impose on the nation's health care system. The study shall also examine the complexity of the current regulatory system and its impact on providers.

(2) REPORT.—Not later than December 31, 2001, the Commission shall submit to Congress one or more reports on the study conducted under paragraph (1). The report shall include recommendations regarding—

(A) how the Health Care Financing Administration can reduce the regulatory burdens placed on patients and providers; and

(B) legislation that may be appropriate to reduce the complexity of the medicare program, including improvement of the rules regarding billing, compliance, and fraud and abuse.

(d) GAO CONTINUED MONITORING OF DEPARTMENT OF JUSTICE APPLICATION OF GUIDELINES ON USE OF FALSE CLAIMS ACT IN CIVIL HEALTH CARE MATTERS.—The Comptroller General of the United States shall—

(1) continue the monitoring, begun under section 118 of the Department of Justice Appropriations Act, 1999 (included in Public Law 105–277) of the compliance of the Department of Justice and all United States Attorneys with the ''Guidance on the Use of the False Claims Act in Civil Health Care Matters'' issued by the Department of Justice on June 3, 1998, including any revisions to that guidance; and

(2) not later than April 1, 2000, and of each of the two succeeding years, submit a report on such compliance to the appropriate Committees of Congress.

TITLE III—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 301. ADJUSTMENT TO REFLECT ADMINISTRATIVE COSTS NOT INCLUDED IN THE INTERIM PAYMENT SYSTEM; GAO REPORT ON COSTS OF COMPLIANCE WITH OASIS DATA COLLECTION REQUIREMENTS.

(a) ADJUSTMENT TO REFLECT ADMINISTRATIVE COSTS.—

(1) IN GENERAL.—In the case of a home health agency that furnishes home health services to a medicare beneficiary, for each such beneficiary to whom the agency furnished such services during the agency's cost reporting period beginning in fiscal year 2000, the Secretary of Health and Human Services shall pay the agency, in addition to any amount of payment made under section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)) for the beneficiary and only for such cost reporting period, an aggregate amount of $10 to defray costs incurred by the agency attributable to data collection and reporting requirements under the Outcome and Assessment Information Set (OASIS) required by reason of section 4602(e) of BBA (42 U.S.C. 1395fff note).

(2) PAYMENT SCHEDULE.—

(A) MIDYEAR PAYMENT.—Not later than April 1, 2000, the Secretary shall pay to a home health agency an amount that the Secretary estimates to be 50 percent of the aggregate amount payable to the agency by reason of this subsection.

(B) UPON SETTLED COST REPORT.—The Secretary shall pay the balance of amounts payable to an agency under this subsection on the date that the cost report submitted by the agency for the cost reporting period beginning in fiscal year 2000 is settled.

(3) PAYMENT FROM TRUST FUNDS.—Payments under this subsection shall be made, in appropriate part as specified by the Secretary, from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund.

(4) DEFINITIONS.—In this subsection:

(A) HOME HEALTH AGENCY.—The term ''home health agency'' has the meaning given that term under section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(B) HOME HEALTH SERVICES.—The term ''home health services'' has the meaning given that

term under section 1861(m) of such Act (42 U.S.C. 1395x(m)).

(C) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means a beneficiary described in section 1861(v)(1)(L)(vi)(II) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(vi)(II)).

(b) GAO REPORT ON COSTS OF COMPLIANCE WITH OASIS DATA COLLECTION REQUIREMENTS.—

(1) REPORT TO CONGRESS.—

(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the matters described in subparagraph (B) with respect to the data collection requirement of patients of such agencies under the Outcome and Assessment Information Set (OASIS) standard as part of the comprehensive assessment of patients.

(B) MATTERS STUDIED.—For purposes of subparagraph (A), the matters described in this subparagraph include the following:

(i) An assessment of the costs incurred by medicare home health agencies in complying with such data collection requirement.

(ii) An analysis of the effect of such data collection requirement on the privacy interests of patients from whom data is collected.

(C) AUDIT.—The Comptroller General shall conduct an independent audit of the costs described in subparagraph (B)(i). Not later than 180 days after receipt of the report under subparagraph (A), the Comptroller General shall submit to Congress a report describing the Comptroller General's findings with respect to such audit, and shall include comments on the report submitted to Congress by the Secretary of Health and Human Services under subparagraph (A).

(2) DEFINITIONS.—In this subsection:

(A) COMPREHENSIVE ASSESSMENT OF PATIENTS.—The term ''comprehensive assessment of patients'' means the rule published by the Health Care Financing Administration that requires, as a condition of participation in the medicare program, a home health agency to provide a patient-specific comprehensive assessment that accurately reflects the patient's current status and that incorporates the Outcome and Assessment Information Set (OASIS).

(B) OUTCOME AND ASSESSMENT INFORMATION SET.—The term ''Outcome and Assessment Information Set'' means the standard provided under the rule relating to data items that must be used in conducting a comprehensive assessment of patients.

SEC. 302. DELAY IN APPLICATION OF 15 PERCENT REDUCTION IN PAYMENT RATES FOR HOME HEALTH SERVICES UNTIL ONE YEAR AFTER IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.

(a) CONTINGENCY REDUCTION.—Section 4603 of BBA (42 U.S.C. 1395fff note) (as amended by section 5101(c)(3) of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105–277)) is amended by striking subsection (e).

(b) PROSPECTIVE PAYMENT SYSTEM.—Section 1895(b)(3)(A)(i) (42 U.S.C. 1395fff(b)(3)(A)(i)) (as amended by section 5101 of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105–277)) is amended to read as follows:

''(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts) as follows:

''(I) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for the 12-month period beginning on the date the Secretary implements the system shall be equal to the total amount that would have been made if the system had not been in effect.

''(II) For periods beginning after the period described in subclause (I), such amount (or amounts) shall be equal to the amount (or amounts) that would have been determined under subclause (I) that would have been made for fiscal year 2001 if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect, updated under subparagraph (B).

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.''.

(c) REPORT.—Not later than the date that is six months after the date the Secretary of Health and Human Services implements the prospective payment system for home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff), the Secretary shall submit to Congress a report analyzing the need for the 15 percent reduction under subsection (b)(3)(A)(ii) of such section, or for any reduction, in the computation of the base payment amounts under the prospective payment system for home health services established under such section.

SEC. 303. INCREASE IN PER BENEFICIARY LIMITS.

(a) INCREASE IN PER BENEFICIARY LIMITS.—Section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)), as amended by section 5101 of the Tax and Trade Relief Extension Act of 1998 (contained in Division J of Public Law 105–277), is amended—

(1) by redesignating clause (ix) as clause (x); and

(2) by inserting after clause (viii) the following new clause:

''(ix) Notwithstanding the per beneficiary limit under clause (viii), if the limit imposed under clause (v) (determined without regard to this clause) for a cost reporting period beginning during or after fiscal year 2000 is less than the median described in clause (vi)(I) (but determined as if any reference in clause (v) to '98 percent' were a reference to '100 percent'), the limit otherwise imposed under clause (v) for such provider and period shall be increased by 2 percent.''.

(b) INCREASE NOT INCLUDED IN PPS BASE.—The second sentence of section 1895(b)(3)(A)(i) (42 U.S.C. 1395fff(b)(3)(A)(i)), as amended by section 302(b), is further amended—

(1) in subclause (I), by inserting ''and if section 1861(v)(1)(L)(ix) had not been enacted'' before the semicolon; and

(2) in subclause (II), by inserting ''and if section 1861(v)(1)(L)(ix) had not been enacted'' after ''if the system had not been in effect''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1999.

SEC. 304. CLARIFICATION OF SURETY BOND REQUIREMENTS.

(a) HOME HEALTH AGENCIES.—Section 1861(o)(7) (42 U.S.C. 1395x(o)(7)) is amended to read as follows:

''(7) provides the Secretary with a surety bond—

''(A) effective for a period of 4 years (as specified by the Secretary) or in the case of a change in the ownership or control of the agency (as determined by the Secretary) during or after such 4-year period, an additional period of time that the Secretary determines appropriate, such additional period not to exceed 4 years from the date of such change in ownership or control;

''(B) in a form specified by the Secretary; and

''(C) for a year in the period described in subparagraph (A) in an amount that is equal to the lesser of $50,000 or 10 percent of the aggregate amount of payments to the agency under this title and title XIX for that year, as estimated by the Secretary; and''.

(b) COORDINATION OF SURETY BONDS.—Part A of title XI of the Social Security Act is amended by inserting after section 1128E the following new section:

''COORDINATION OF MEDICARE AND MEDICAID SURETY BOND PROVISIONS

''SEC. 1128F. In the case of a home health agency that is subject to a surety bond requirement under title XVIII and title XIX, the surety bond provided to satisfy the requirement under one such title shall satisfy the requirement under the other such title so long as the bond applies to guarantee return of overpayments under both such titles.''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act, and in applying section 1861(o)(7) of the Social Security Act (42 U.S.C. 1395x(o)(7)), as amended by subsection (a), the Secretary of Health and Human Services may take into account the previous period for which a home health agency had a surety bond in effect under such section before such date.

SEC. 305. REFINEMENT OF HOME HEALTH AGENCY CONSOLIDATED BILLING.

(a) IN GENERAL.—Section 1842(b)(6)(F) (42 U.S.C. 1395u(b)(6)(F)) is amended by inserting ''(including medical supplies described in section 1861(m)(5), but excluding durable medical equipment to the extent provided for in such section)'' after ''home health services''.

(b) CONFORMING AMENDMENT.—Section 1862(a)(21) (42 U.S.C. 1395y(a)(21)) is amended by inserting ''(including medical supplies described in section 1861(m)(5), but excluding durable medical equipment to the extent provided for in such section)'' after ''home health services''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments for services provided on or after the date of enactment of this Act.

SEC. 306. TECHNICAL AMENDMENT CLARIFYING APPLICABLE MARKET BASKET INCREASE FOR PPS.

Section 1895(b)(3)(B)(ii)(I) (42 U.S.C. 1395fff(b)(3)(B)(ii)(I)) is amended by striking ''fiscal year 2002 or 2003'' and inserting ''each of fiscal years 2002 and 2003''.

SEC. 307. STUDY AND REPORT TO CONGRESS REGARDING THE EXEMPTION OF RURAL AGENCIES AND POPULATIONS FROM INCLUSION IN THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM.

(a) STUDY.—The Medicare Payment Advisory Commission (referred to in this section as ''MedPAC'') shall conduct a study to determine the feasibility and advisability of exempting home health services provided by a home health agency (or by others under arrangements with such agency) located in a rural area, or to an individual residing in a rural area, from payment under the prospective payment system for such services established by the Secretary of Health and Human Services in accordance with section 1895 of the Social Security Act (42 U.S.C. 1395fff).

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, MedPAC shall submit a report to Congress on the study conducted under subsection (a), together with any recommendations for legislation that MedPAC determines to be appropriate as a result of such study.

Subtitle B—Direct Graduate Medical Education

SEC. 311. USE OF NATIONAL AVERAGE PAYMENT METHODOLOGY IN COMPUTING DIRECT GRADUATE MEDICAL EDUCATION (DGME) PAYMENTS.

(a) IN GENERAL.—Section 1886(h)(2) (42 U.S.C. 1395ww(h)(2)) is amended—

(1) in subparagraph (D)(i), by striking ''clause (ii)'' and inserting ''a subsequent clause'';

(2) by adding at the end of subparagraph (D) the following new clauses:

''(iii) FLOOR IN FISCAL YEAR 2001 AT 70 PERCENT OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—The approved FTE resident amount for a hospital for the cost reporting period beginning during fiscal year 2001 shall not be less than 70 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for the hospital and period.

''(iv) ADJUSTMENT IN RATE OF INCREASE FOR HOSPITALS WITH FTE APPROVED AMOUNT ABOVE 140 PERCENT OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—

''(I) FREEZE FOR FISCAL YEARS 2001 AND 2002.—For a cost reporting period beginning during fiscal year 2001 or fiscal year 2002, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and period, subject to subclause (III), the approved FTE resident amount for the period involved shall be the same as the approved FTE resident amount for the hospital for such preceding cost reporting period.

''(II) 2 PERCENT DECREASE IN UPDATE FOR FISCAL YEARS 2003, 2004, AND 2005.—For a cost reporting period beginning during fiscal year 2003, fiscal year 2004, or fiscal year 2005, if the approved FTE resident amount for a hospital for the preceding cost reporting period exceeds 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital and preceding period, the approved FTE resident amount for the period involved shall be updated in the manner described in subparagraph (D)(i) except that, subject to subclause (III), the consumer price index applied for a 12-month period shall be reduced (but not below zero) by 2 percentage points.

''(III) NO ADJUSTMENT BELOW 140 PERCENT.—In no case shall subclause (I) or (II) reduce an approved FTE resident amount for a hospital for a cost reporting period below 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) for such hospital and period.'';

(3) by redesignating subparagraph (E) as subparagraph (F); and

(4) by inserting after subparagraph (D) the following new subparagraph:

''(E) DETERMINATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—The Secretary shall determine a locality adjusted national average per resident amount with respect to a cost reporting period of a hospital beginning during a fiscal year as follows:

''(i) DETERMINING HOSPITAL SINGLE PER RESIDENT AMOUNT.—The Secretary shall compute for each hospital operating an approved graduate medical education program a single per resident amount equal to the average (weighted by number of full-time equivalent residents, as determined under paragraph (4)) of the primary care per resident amount and the non-primary care per resident amount computed under paragraph (2) for cost reporting periods ending during fiscal year 1997.

''(ii) STANDARDIZING PER RESIDENT AMOUNTS.—The Secretary shall compute a standardized per resident amount for each such hospital by dividing the single per resident amount computed under clause (i) by an average of the 3 geographic index values (weighted by the national average weight for each of the work, practice expense, and malpractice components) as applied under section 1848(e) for 1999 for the fee schedule area in which the hospital is located.

''(iii) COMPUTING OF WEIGHTED AVERAGE.—The Secretary shall compute the average of the standardized per resident amounts computed under clause (ii) for such hospitals, with the amount for each hospital weighted by the average number of full-time equivalent residents at such hospital (as determined under paragraph (4)).

''(iv) COMPUTING NATIONAL AVERAGE PER RESIDENT AMOUNT.—The Secretary shall compute the national average per resident amount, for a hospital's cost reporting period that begins during fiscal year 2001, equal to the weighted average computed under clause (iii) increased by the estimated percentage increase in the consumer price index for all urban consumers during the period beginning with the month that represents the midpoint of the cost reporting periods described in clause (i) and ending with the midpoint of the hospital's cost reporting period that begins during fiscal year 2001.

''(v) ADJUSTING FOR LOCALITY.—The Secretary shall compute the product of—

''(I) the national average per resident amount computed under clause (iv) for the hospital, and

''(II) the geographic index value average (described and applied under clause (ii)) for the fee schedule area in which the hospital is located.

''(vi) COMPUTING LOCALITY ADJUSTED AMOUNT.—The locality adjusted national per resident amount for a hospital for—

''(I) the cost reporting period beginning during fiscal year 2001 is the product computed under clause (v); or

''(II) each subsequent cost reporting period is equal to the locality adjusted national per resident amount for the hospital for the previous cost reporting period (as determined under this clause) updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index for all urban consumers during the 12-month period ending at that midpoint.''.

(b) CONFORMING AMENDMENTS.—Section 1886(h)(2)(D) (42 U.S.C. 1395ww(h)(2)(D)) is further amended—

(1) in clause (i)—

(A) by striking ''PERIODS.—(i)'' and inserting the following (and conforming the indentation of the succeeding matter accordingly): ''PERIODS.—

''(i) IN GENERAL.—''; and

(B) by striking ''the amount determined'' and inserting ''the approved FTE resident amount determined''; and

(2) in clause (ii)—

(A) by indenting the clause 2 ems to the right; and

(B) by inserting ''FREEZE IN UPDATE FOR FISCAL YEARS 1994 AND 1995.—'' after ''(ii)''.

SEC. 312. INITIAL RESIDENCY PERIOD FOR CHILD NEUROLOGY RESIDENCY TRAINING PROGRAMS.

(a) IN GENERAL.—Section 1886(h)(5) (42 U.S.C. 1395ww(h)(5)) is amended—

(1) in the last sentence of subparagraph (F), by striking ''The initial residency period'' and inserting ''Subject to subparagraph (G)(v), the initial residency period''; and

(2) in subparagraph (G)—

(A) in clause (i) by striking ''and (iv)'' and inserting ''(iv), and (v)''; and

(B) by adding at the end the following new clause:

''(v) CHILD NEUROLOGY TRAINING PROGRAMS.—In the case of a resident enrolled in a child neurology residency training program, the period of board eligibility and the initial residency period shall be the period of board eligibility for pediatrics plus 2 years.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply on and after July 1, 2000, to residency programs that began before, on, or after the date of the enactment of this Act.

(c) MEDPAC REPORT.—The Medicare Payment Advisory Commission shall include in its report submitted to Congress in March of 2001 recommendations regarding the appropriateness of the initial residency period used under section 1886(h)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)) for other residency training programs in a specialty that require preliminary years of study in another specialty.

Subtitle C—Technical Corrections

SEC. 321. BBA TECHNICAL CORRECTIONS.

(a) SECTION 4201.—Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i–4(c)(2)(B)(i)) is amended by striking ''and is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) that'' and inserting ''that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)), and that''.

(b) SECTION 4204.—(1) Section 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(A) in clause (i), by striking ''or beginning on or after October 1, 1997, and before October 1, 2001,'' and inserting ''or discharges occurring on or after October 1, 1997, and before October 1, 2001,''; and

(B) in clause (ii)(II), by striking ''or beginning on or after October 1, 1997, and before October 1, 2001,'' and inserting ''or discharges occurring on or after October 1, 1997, and before October 1, 2001,''.

(2) Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended in the matter preceding clause (i) by striking ''and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001,'' and inserting ''and for discharges beginning on or after October 1, 1997, and before October 1, 2001,''.

(c) SECTION 4319.—Section 1847(b)(2) (42 U.S.C. 1395w–3(b)(2)) is amended by inserting ''and'' after ''specified by the Secretary''.

(d) SECTION 4401.—Section 4401(b)(1)(B) of BBA (42 U.S.C. 1395ww note) is amended by striking ''section 1886(b)(3)(B)(i)(XIII) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIII)))'' and inserting ''section 1886(b)(3)(B)(i)(XIV) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIV)))''.

(e) SECTION 4402.—The last sentence of section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by striking ''September 30, 2002,'' and inserting ''October 1, 2002,''.

(f) SECTION 4419.—The first sentence of section 1886(b)(4)(A)(i) (42 U.S.C. 1395ww(b)(4)(A)(i)) is amended by striking ''or unit''.

(g) SECTION 4432.—(1) Section 1888(e)(8)(B) (42 U.S.C. 1395yy(e)(8)(B)) is amended by striking ''January 1, 1999,'' and inserting ''July 1, 1999''.

(2) Section 1833(h)(5)(A)(iii) (42 U.S.C. 1395l(h)(5)(A)(iii)) is amended—

(A) by striking ''or critical access hospital,'' and inserting '', critical access hospital, or skilled nursing facility,''; and

(B) by inserting ''or skilled nursing facility'' before the period.

(h) SECTION 4416.—Section 1886(b)(7)(A)(i)(II) (42 U.S.C. 1395ww(b)(7)(A)(i)(II)) is amended by inserting ''(as estimated by the Secretary)'' after ''median''.

(i) SECTION 4442.—Section 4442(b) of BBA (42 U.S.C. 1395f note) is amended by striking ''applies to cost reporting periods beginning'' and inserting ''applies to items and services furnished''.

(j) HIPAA SECTION 201.—

(1) IN GENERAL.—Section 1817(k)(2)(C)(i) (42 U.S.C. 1395i(k)(2)(C)(i)) is amended by striking ''section 982(a)(6)(B)'' and inserting ''section 24(a)''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall take effect as if included in the amendment made by section 201 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1992).

(k) OTHER TECHNICAL AMENDMENTS.—

(1) SECTION 4611.—Section 1812(b) (42 U.S.C. 1395d(b)) is amended in the matter following paragraph (3) by inserting ''during'' after ''100 visits''.

(2) SECTION 4511.—Section 1833(a)(1)(O) (42 U.S.C. 1395l(a)(1)(O)) is amended by striking the semicolon and inserting a comma.

(3) SECTION 4551.—Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended—

(A) in clause (i), by striking the comma at the end and inserting a semicolon; and

(B) in clause (v), by striking '', and'' and inserting ''; and''.

(4) SECTION 4315.— Section 1842(s)(2)(E) (42 U.S.C. 1395u(s)(2)(E)) is amended by inserting a period at the end.

(5) SECTIONS 4103, 4104, AND 4106.—

(A) SECTION 4103.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by striking ''1861(oo)(2),'' and inserting ''1861(oo)(2))''.

(B) SECTION 4104.—Such section is further amended by striking ''(B) ,'' and inserting ''(B),''.

(C) SECTION 4106.—Such section is further amended by striking ''and (15)'' and inserting '', and (15)''.

(6) SECTION 4001.—(A) Section 1851(i)(2) (42 U.S.C. 1395w–21(i)(2)) is amended by striking ''and'' after ''1857(f)(2),''.

(B) Section 1852 (42 U.S.C. 1395w–22) is amended—

(i) in subsection (a)(3)(A)—

(I) by striking the comma after ''MSA plan''; and

(II) by inserting a comma after ''the coverage)'';

(ii) in subsection (g)—

(I) in paragraph (1)(B), by inserting ''or'' after ''in whole''; and

(II) in paragraph (3)(B)(ii), by inserting a period at the end;

(iii) in subsection (h)(2), by striking the comma and inserting a semicolon; and

(iv) in subsection (k)(2)(C)(ii), by striking ''balancing'' and inserting ''balance''.

(C) Section 1854(a) (42 U.S.C. 1395w–24(a)) is amended—

(i) in paragraph (2)—

(I) in subparagraph (A), in the matter preceding clause (i), by inserting ''section'' before ''1852(a)(1)(A)''; and

(II) in subparagraph (B), in the matter preceding clause (i), by inserting ''section'' after ''described in'';

(ii) in paragraph (3)—

(I) in subparagraph (A), by inserting ''section'' after ''described in''; and

(II) in subparagraph (B), by inserting ''section'' after ''described in''; and

(iii) in paragraph (4)—

(I) in the matter preceding subparagraph (A), by inserting ''section'' after ''described in'';

(II) in subparagraph (A), in the matter preceding clause (i), by inserting ''section'' after ''described in''; and

(III) in subparagraph (B), by inserting ''section'' after ''described in''.

(7) SECTION 4557.—Section 1861(s)(2)(T)(ii) (42 U.S.C. 1395x(s)(2)(T)(ii)) is amended by striking the period and inserting a semicolon.

(8) SECTION 4205.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended—

(A) in subparagraph (I), by striking the comma at the end and inserting a semicolon; and

(B) by realigning subparagraph (I) so as to align the left margin of such subparagraph with the left margin of subparagraph (H); and

(9) SECTION 4454.—Section 1861(ss)(1)(G)(i) (42 U.S.C. 1395x(ss)(1)(G)(i)) is amended—

(A) by striking ''owed'' and inserting ''owned''; and

(B) by striking ''of'' and inserting ''or''.

(10) SECTION 4103.—Section 1862(a)(7) (42 U.S.C. 1395y(a)(7)) is amended by striking ''subparagraphs'' and inserting ''subparagraph''.

(11) SECTION 4002.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(A) in subparagraph (I)(iii), by striking the semicolon and inserting a comma;

(B) in subparagraph (N)(iv), by striking ''and'' at the end; and

(C) in subparagraph (O), by striking the semicolon at the end and inserting a comma.

(12) SECTION 4321.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(A) in subparagraph (Q), by striking the semicolon at the end and inserting a comma; and

(B) in subparagraph (R), by inserting '', and'' at the end.

(13) SECTION 4003.—Section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by striking ''or'' after ''does not include''.

(14) SECTION 4031.—Section 1882(s)(2)(D) (42 U.S.C. 1395ss(s)(2)(D)), is amended in the matter preceding clause (i), by inserting ''section'' after ''as defined in''.

(15) SECTION 4421.—Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

(A) in paragraph (1), in the matter following subparagraph (C), by inserting a comma after ''paragraph (2)''; and

(B) in paragraph (3)(B)(ii)—

(i) in subclause (VI), by striking the semicolon and inserting a comma; and

(ii) in subclause (VII), by striking the semicolon and inserting a comma.

(16) SECTION 4403.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by inserting a comma after ''1986''.

(17) SECTION 4406.—Section 1886(d)(9)(A)(ii) (42 U.S.C. 1395ww(d)(9)(A)(ii)) is amended by inserting a comma after ''1987''.

(18) SECTION 4432.—Section 1888(e)(4)(E) (42 U.S.C. 1395yy(e)(4)(E)) is amended—

(A) in clause (i), by striking ''federal'' and inserting ''Federal''; and

(B) in clause (ii), in the matter preceding subclause (I), by striking ''federal'' each place it appears and inserting ''Federal''.

(19) SECTION 4603.—Section 1895(b)(1) (42 U.S.C. 1395fff(b)(1)) is amended by striking ''the this section'' and inserting ''this section''.

(l) SECTION 1135 OF THE SOCIAL SECURITY ACT.—Effective on the date of the enactment of this Act, section 1135 (42 U.S.C. 1320b–5) is repealed.

(m) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall take effect as if included in the enactment of BBA.

TITLE IV—RURAL PROVIDER PROVISIONS

Subtitle A—Rural Hospitals

SEC. 401. PERMITTING RECLASSIFICATION OF CERTAIN URBAN HOSPITALS AS RURAL HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(8) (42 U.S.C. 1395ww(d)(8)) is amended by adding at the end the following new subparagraph:

''(E)(i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary shall treat the hospital as being located in the rural area (as defined in paragraph (2)(D)) of the State in which the hospital is located.

''(ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:

''(I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

''(II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).

''(III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.

''(IV) The hospital meets such other criteria as the Secretary may specify.''.

(b) CONFORMING CHANGES.—(1) Section 1833(t) (42 U.S.C. 1395l(t)), as amended by sections 201 and 202, is further amended by adding at the end the following new paragraph:

''(13) MISCELLANEOUS PROVISIONS.—

''(A) APPLICATION OF RECLASSIFICATION OF CERTAIN HOSPITALS.—If a hospital is being treated as being located in a rural area under section 1886(d)(8)(E), that hospital shall be treated under this subsection as being located in that rural area.''.

(2) Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i–4(c)(2)(B)(i)) is amended, in the matter preceding subclause (I), by inserting ''or is treated as being located in a rural area pursuant to section 1886(d)(8)(E)'' after ''section 1886(d)(2)(D))''.

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective on January 1, 2000.

SEC. 402. UPDATE OF STANDARDS APPLIED FOR GEOGRAPHIC RECLASSIFICATION FOR CERTAIN HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(8)(B) (42 U.S.C. 1395ww(d)(8)(B)) is amended—

(1) by inserting ''(i)'' after ''(B)'';

(2) by striking ''published in the Federal Register on January 3, 1980'' and inserting ''described in clause (ii)''; and

(3) by adding at the end the following new clause:

''(ii) The standards described in this clause for cost reporting periods beginning in a fiscal year—

''(I) before fiscal year 2003, are the standards published in the Federal Register on January 3, 1980, or, at the election of the hospital with respect to fiscal years 2001 and 2002, standards so published on March 30, 1990; and

''(II) after fiscal year 2002, are the standards published in the Federal Register by the Director of the Office of Management and Budget based on the most recent available decennial population data.

Subparagraphs (C) and (D) shall not apply with respect to the application of subclause (I).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply with respect to discharges occurring during cost reporting periods beginning on or after October 1, 1999.

SEC. 403. IMPROVEMENTS IN THE CRITICAL ACCESS HOSPITAL (CAH) PROGRAM.

(a) APPLYING 96-HOUR LIMIT ON AN ANNUAL, AVERAGE BASIS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended by striking ''for a period not to exceed 96 hours'' and all that follows and inserting ''for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on the date of the enactment of this Act.

(b) PERMITTING FOR-PROFIT HOSPITALS TO QUALIFY FOR DESIGNATION AS A CRITICAL ACCESS HOSPITAL.—Section 1820(c)(2)(B)(i) (42 U.S.C. 1395i–4(c)(2)(B)(i)) is amended in the matter preceding subclause (I), by striking ''nonprofit or public hospital'' and inserting ''hospital''.

(c) ALLOWING CLOSED OR DOWNSIZED HOSPITALS TO CONVERT TO CRITICAL ACCESS HOSPITALS.—Section 1820(c)(2) (42 U.S.C. 1395i–4(c)(2)) is amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B), (C), and (D)''; and

(2) by adding at the end the following new subparagraphs:

''(C) RECENTLY CLOSED FACILITIES.—A State may designate a facility as a critical access hospital if the facility—

''(i) was a hospital that ceased operations on or after the date that is 10 years before the date of the enactment of this subparagraph; and

''(ii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).

''(D) DOWNSIZED FACILITIES.—A State may designate a health clinic or a health center (as defined by the State) as a critical access hospital if such clinic or center—

''(i) is licensed by the State as a health clinic or a health center;

''(ii) was a hospital that was downsized to a health clinic or health center; and

''(iii) as of the effective date of such designation, meets the criteria for designation under subparagraph (B).''.

(d) ELECTION OF COST-BASED PAYMENT OPTION FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

(1) IN GENERAL.—Section 1834(g) (42 U.S.C. 1395m(g)) is amended to read as follows:

''(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

''(1) IN GENERAL.—The amount of payment for outpatient critical access hospital services of a critical access hospital is the reasonable costs of the hospital in providing such services, unless the hospital makes the election under paragraph (2).

''(2) ELECTION OF COST-BASED HOSPITAL OUTPATIENT SERVICE PAYMENT PLUS FEE SCHEDULE FOR PROFESSIONAL SERVICES.—A critical access hospital may elect to be paid for outpatient critical access hospital services amounts equal to the sum of the following, less the amount that such hospital may charge as described in section 1866(a)(2)(A):

''(A) FACILITY FEE.—With respect to facility services, not including any services for which payment may be made under subparagraph (B), the reasonable costs of the critical access hospital in providing such services.

''(B) FEE SCHEDULE FOR PROFESSIONAL SERVICES.—With respect to professional services otherwise included within outpatient critical access hospital services, such amounts as would otherwise be paid under this part if such services were not included in outpatient critical access hospital services.

''(3) DISREGARDING CHARGES.—The payment amounts under this subsection shall be determined without regard to the amount of the customary or other charge.''.

(2) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply for cost reporting periods beginning on or after October 1, 2000.

(e) ELIMINATION OF COINSURANCE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY A CRITICAL ACCESS HOSPITAL ON AN OUTPATIENT BASIS.—

(1) IN GENERAL.—Paragraphs (1)(D)(i) and (2)(D)(i) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by inserting ''or which are furnished on an outpatient basis by a critical access hospital'' after ''on an assignment-related basis''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to services furnished on or after the date of the enactment of this Act.

(f) PARTICIPATION IN SWING BED PROGRAM.—Section 1883 (42 U.S.C. 1395tt) is amended—

(1) in subsection (a)(1), by striking ''(other than a hospital which has in effect a waiver under subparagraph (A) of the last sentence of section 1861(e))''; and

(2) in subsection (c), by striking '', or during which there is in effect for the hospital a waiver under subparagraph (A) of the last sentence of section 1861(e)''.

SEC. 404. 5-YEAR EXTENSION OF MEDICARE DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) EXTENSION OF PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking ''and before October 1, 2001,'' and inserting ''and before October 1, 2006,''; and

(2) in clause (ii)(II), by striking ''and before October 1, 2001,'' and inserting ''and before October 1, 2006,''.

(b) CONFORMING AMENDMENTS.—

(1) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking ''and before October 1, 2001,'' and inserting ''and before October 1, 2006,''; and

(B) in clause (iv), by striking ''during fiscal year 1998 through fiscal year 2000'' and inserting ''during fiscal year 1998 through fiscal year 2005''.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note), as amended by section 4204(a)(3) of BBA, is amended by striking ''or fiscal year 2000'' and inserting ''or fiscal year 2000 through fiscal year 2005''.

SEC. 405. REBASING FOR CERTAIN SOLE COMMUNITY HOSPITALS.

Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)) is amended—

(1) in subparagraph (C), by inserting ''subject to subparagraph (I),'' before ''the term 'target amount' means''; and

(2) by adding at the end the following new subparagraph:

''(I)(i) For cost reporting periods beginning on or after October 1, 2000, in the case of a sole community hospital that for its cost reporting period beginning during 1999 is paid on the basis of the target amount applicable to the hospital under subparagraph (C) and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, there shall be substituted for such target amount—

''(I) with respect to discharges occurring in fiscal year 2001, 75 percent of the target amount otherwise applicable to the hospital under subparagraph (C) (referred to in this clause as the 'subparagraph (C) target amount') and 25 percent of the rebased target amount (as defined in clause (ii));

''(II) with respect to discharges occurring in fiscal year 2002, 50 percent of the subparagraph (C) target amount and 50 percent of the rebased target amount;

''(III) with respect to discharges occurring in fiscal year 2003, 25 percent of the subparagraph (C) target amount and 75 percent of the rebased target amount; and

''(IV) with respect to discharges occurring after fiscal year 2003, 100 percent of the rebased target amount.

''(ii) For purposes of this subparagraph, the 'rebased target amount' has the meaning given the term 'target amount' in subparagraph (C) except that—

''(I) there shall be substituted for the base cost reporting period the 12-month cost reporting period beginning during fiscal year 1996;

''(II) any reference in subparagraph (C)(i) to the 'first cost reporting period' described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after October 1, 2000; and

''(III) applicable increase percentage shall only be applied under subparagraph (C)(iv) for discharges occurring in fiscal years beginning with fiscal year 2002.''.

SEC. 406. ONE YEAR SOLE COMMUNITY HOSPITAL PAYMENT INCREASE.

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) by redesignating subclause (XVII) as subclause (XVIII);

(2) by striking subclause (XVI); and

(3) by inserting after subclause (XV) the following new subclauses:

''(XVI) for fiscal year 2001, the market basket percentage increase minus 1.1 percentage points for hospitals (other than sole community hospitals) in all areas, and the market basket percentage increase for sole community hospitals,

''(XVII) for fiscal year 2002, the market basket percentage increase minus 1.1 percentage points for hospitals in all areas, and''.

SEC. 407. INCREASED FLEXIBILITY IN PROVIDING GRADUATE PHYSICIAN TRAINING IN RURAL AND OTHER AREAS.

(a) COUNTING PRIMARY CARE RESIDENTS ON CERTAIN APPROVED LEAVES OF ABSENCE IN BASE YEAR FTE COUNT.—

(1) PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(4)(F) (42 U.S.C. 1395ww(h)(4)(F)) is amended—

(A) by redesignating the first sentence as clause (i) with the heading ''IN GENERAL.—'' and appropriate indentation; and

(B) by adding at the end the following new clause:

''(ii) COUNTING PRIMARY CARE RESIDENTS ON CERTAIN APPROVED LEAVES OF ABSENCE IN BASE YEAR FTE COUNT.—

''(I) IN GENERAL.—In determining the number of such full-time equivalent residents for a hospital's most recent cost reporting period ending on or before December 31, 1996, for purposes of clause (i), the Secretary shall count an individual to the extent that the individual would have been counted as a primary care resident for such period but for the fact that the individual, as determined by the Secretary, was on maternity or disability leave or a similar approved leave of absence.

''(II) LIMITATION TO 3 FTE RESIDENTS FOR ANY HOSPITAL.—The total number of individuals counted under subclause (I) for a hospital may not exceed 3 full-time equivalent residents.''.

(2) PAYMENT FOR INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended by adding at the end the following: ''Rules similar to the rules of subsection (h)(4)(F)(ii) shall apply for purposes of this clause.''.

(3) EFFECTIVE DATE.—

(A) DGME.—The amendments made by paragraph (1) apply to cost reporting periods that begin on or after the date of the enactment of this Act.

(B) IME.—The amendment made by paragraph (2) applies to discharges occurring in cost reporting periods that begin on or after such date of enactment.

(b) PERMITTING 30 PERCENT EXPANSION IN CURRENT GME TRAINING PROGRAMS FOR HOSPITALS LOCATED IN RURAL AREAS.—

(1) PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(4)(F)(i) (42 U.S.C. 1395ww(h)(4)(F)(i)), as amended by subsection (a)(1), is amended by inserting ''(or, 130 percent of such number in the case of a hospital located in a rural area)'' after ''may not exceed the number''.

(2) PAYMENT FOR INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended by inserting ''(or, 130 percent of such number in the case of a hospital located in a rural area)'' after ''may not exceed the number''.

(3) EFFECTIVE DATES.—

(A) DGME.—The amendment made by paragraph (1) applies to cost reporting periods beginning on or after April 1, 2000.

(B) IME.—The amendment made by paragraph (2) applies to discharges occurring on or after April 1, 2000.

(c) SPECIAL RULE FOR NONRURAL FACILITIES SERVING RURAL AREAS.—

(1) IN GENERAL.—Section 1886(h)(4)(H) (42 U.S.C. 1395ww(h)(4)(H)) is amended by adding at the end the following new clause:

''(iv) NONRURAL HOSPITALS OPERATING TRAINING PROGRAMS IN RURAL AREAS.—In the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in an rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust the limitation under subparagraph (F) in an appropriate manner insofar as it applies to such programs in such rural areas in order to encourage the training of physicians in rural areas.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies with respect to—

(A) payments to hospitals under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) for cost reporting periods beginning on or after April 1, 2000; and

(B) payments to hospitals under section 1886(d)(5)(B)(v) of such Act (42 U.S.C. 1395ww(d)(5)(B)(v)) for discharges occurring on or after April 1, 2000.

(d) NOT COUNTING AGAINST NUMERICAL LIMITATION CERTAIN INTERNS AND RESIDENTS TRANSFERRED FROM A VA RESIDENCY PROGRAM THAT LOSES ACCREDITATION.—

(1) IN GENERAL.—Any applicable resident described in paragraph (2) shall not be taken into account in applying any limitation regarding the number of residents or interns for which payment may be made under section 1886 of the Social Security Act (42 U.S.C. 1395ww).

(2) APPLICABLE RESIDENT DESCRIBED.—An applicable resident described in this paragraph is a resident or intern who—

(A) participated in graduate medical education at a facility of the Department of Veterans Affairs;

(B) was subsequently transferred on or after January 1, 1997, and before July 31, 1998, to a hospital that was not a Department of Veterans Affairs facility; and

(C) was transferred because the approved medical residency program in which the resident or intern participated would lose accreditation by the Accreditation Council on Graduate Medical Education if such program continued to train residents at the Department of Veterans Affairs facility.

(3) EFFECTIVE DATE.—

(A) IN GENERAL.—Paragraph (1) applies as if included in the enactment of BBA.

(B) RETROACTIVE PAYMENTS.—If the Secretary of Health and Human Services determines that a hospital operating an approved medical residency program is owed payments as a result of enactment of this subsection, the Secretary shall make such payments not later than 60 days after the date of the enactment of this Act.

SEC. 408. ELIMINATION OF CERTAIN RESTRICTIONS WITH RESPECT TO HOSPITAL SWING BED PROGRAM.

(a) ELIMINATION OF REQUIREMENT FOR STATE CERTIFICATE OF NEED.—Section 1883(b) (42 U.S.C. 1395tt(b)) is amended to read as follows:

''(b) The Secretary may not enter into an agreement under this section with any hospital unless, except as provided under subsection (g), the hospital is located in a rural area and has less than 100 beds.''.

(b) ELIMINATION OF SWING BED RESTRICTIONS ON CERTAIN HOSPITALS WITH MORE THAN 49 BEDS.—Section 1883(d) (42 U.S.C. 1395tt(d)) is amended—

(1) by striking paragraphs (2) and (3); and

(2) by striking ''(d)(1)'' and inserting ''(d)''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date that is the first day after the expiration of the transition period under section 1888(e)(2)(E) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(E)) for payments for covered skilled nursing facility services under the medicare program.

SEC. 409. GRANT PROGRAM FOR RURAL HOSPITAL TRANSITION TO PROSPECTIVE PAYMENT.

Section 1820(g) (42 U.S.C. 1395i–4(g)) is amended by adding at the end the following new paragraph:

''(3) UPGRADING DATA SYSTEMS.—

''(A) GRANTS TO HOSPITALS.—The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (C) to assist eligible small rural hospitals in meeting the costs of implementing data systems required to meet requirements established under the medicare program pursuant to amendments made by the Balanced Budget Act of 1997.

''(B) ELIGIBLE SMALL RURAL HOSPITAL DEFINED.—For purposes of this paragraph, the term 'eligible small rural hospital' means a non-Federal, short-term general acute care hospital that—

''(i) is located in a rural area (as defined for purposes of section 1886(d)); and

''(ii) has less than 50 beds.

''(C) APPLICATION.—A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

''(D) AMOUNT OF GRANT.—A grant to a hospital under this paragraph may not exceed $50,000.

''(E) USE OF FUNDS.—A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware, the education and training of hospital staff on computer information systems, and to offset costs related to the implementation of prospective payment systems.

''(F) REPORTS.—

''(i) INFORMATION.—A hospital receiving a grant under this section shall furnish the Secretary with such information as the Secretary may require to evaluate the project for which the grant is made and to ensure that the grant is expended for the purposes for which it is made.

''(ii) TIMING OF SUBMISSION.—

''(I) INTERIM REPORTS.—The Secretary shall report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate at least annually on the grant program established under this section, including in such report information on the number of grants made, the nature of the projects involved, the geographic distribution of grant recipients, and such other matters as the Secretary deems appropriate.

''(II) FINAL REPORT.—The Secretary shall submit a final report to such committees not later than 180 days after the completion of all of the projects for which a grant is made under this section.''.

SEC. 410. GAO STUDY ON GEOGRAPHIC RECLASSIFICATION.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study of the current laws and regulations for geographic reclassification of hospitals to determine whether such reclassification is appropriate for purposes of applying wage indices under the medicare program and whether such reclassification results in more accurate payments for all hospitals. Such study shall examine data on the number of hospitals that are reclassified and their reclassified status in determining payments under the medicare program. The study shall evaluate—

(1) the magnitude of the effect of geographic reclassification on rural hospitals that are not reclassified;

(2) whether the current thresholds used in geographic reclassification reclassify hospitals to the appropriate labor markets;

(3) the effect of eliminating geographic reclassification through use of the occupational mix data;

(4) the group reclassification policy;

(5) changes in the number of reclassifications and the compositions of the groups;

(6) the effect of State-specific budget neutrality compared to national budget neutrality; and

(7) whether there are sufficient controls over the intermediary evaluation of the wage data reported by hospitals.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a).

Subtitle B—Other Rural Provisions

SEC. 411. MEDPAC STUDY OF RURAL PROVIDERS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of rural providers furnishing items and services for which payment is made under title XVIII of the Social Security Act. Such study shall examine and evaluate the adequacy and appropriateness of the categories of special payments (and payment methodologies) established for rural hospitals under the medicare program, and the impact of such categories on beneficiary access and quality of health care services.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the study conducted under subsection (a).

SEC. 412. EXPANSION OF ACCESS TO PARAMEDIC INTERCEPT SERVICES IN RURAL AREAS.

(a) EXPANSION OF PAYMENT AREAS.—Section 4531(c) of BBA (42 U.S.C. 1395x note) is amended by adding at the end the following flush sentence:

''For purposes of this subsection, an area shall be treated as a rural area if it is designated as a rural area by any law or regulation of the State or if it is located in a rural census tract of a metropolitan statistical area (as determined under the most recent Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on January 1, 2000, and applies to ALS intercept services furnished on or after such date.

SEC. 413. PROMOTING PROMPT IMPLEMENTATION OF INFORMATICS, TELEMEDICINE, AND EDUCATION DEMONSTRATION PROJECT.

Section 4207 of BBA (42 U.S.C. 1395b-1 note) is amended—

(1) in subsection (a)(1), by adding at the end the following: ''The Secretary shall make an award for such project not later than 3 months after the date of the enactment of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999. The Secretary shall accept the proposal adjudged to be the best technical proposal as of such date of enactment without the need for additional review or resubmission of proposals.'';

(2) in subsection (a)(2)(A), by inserting before the period at the end the following: ''that qualify as Federally designated medically underserved areas or health professional shortage areas at the time of enrollment of beneficiaries under the project'';

(3) in subsection (c)(2), by striking ''and the source and amount of non-Federal funds used in the project'';

(4) in subsection (d)(2)(A), by striking ''at a rate of 50 percent of the costs that are reasonable and'' and inserting ''for the costs that are'';

(5) in subsection (d)(2)(B)(i), by striking ''(but only in the case of patients located in medically underserved areas)'' and inserting ''or at sites providing health care to patients located in medically underserved areas'';

(6) in subsection (d)(2)(C)(i), by striking ''to deliver medical informatics services under'' and inserting ''for activities related to''; and

(7) by amending paragraph (4) of subsection (d) to read as follows:

''(4) COST-SHARING.—The project may not impose cost-sharing on a medicare beneficiary for the receipt of services under the project. Project costs will cover all costs to medicare beneficiaries and providers related to participation in the project.''.

TITLE V—PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PROGRAM) AND OTHER MEDICARE MANAGED CARE PROVISIONS

Subtitle A—Provisions To Accommodate and Protect Medicare Beneficiaries

SEC. 501. CHANGES IN MEDICARE+CHOICE ENROLLMENT RULES.

(a) PERMITTING ENROLLMENT IN ALTERNATIVE MEDICARE+CHOICE PLANS AND MEDIGAP COVERAGE IN CASE OF INVOLUNTARY TERMINATION OF MEDICARE+CHOICE ENROLLMENT.—

(1) IN GENERAL.—Section 1851(e)(4) (42 U.S.C. 1395w–21(e)(4)) is amended by striking subparagraph (A) and inserting the following:

''(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

''(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;''.

(2) CONFORMING MEDIGAP AMENDMENT.—Section 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended—

(A) in subparagraph (A) in the matter following clause (iii), by inserting '', subject to subparagraph (E),'' after ''in the case of an individual described in subparagraph (B) who''; and

(B) by adding at the end the following new subparagraph:

''(E)(i) An individual described in subparagraph (B)(ii) may elect to apply subparagraph (A) by substituting, for the date of termination of enrollment, the date on which the individual was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.

''(ii) In the case of an individual making such an election, the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under subparagraph (A) shall only become effective upon termination of coverage under the Medicare+Choice plan involved.''.

(b) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—Section 1851(e)(2) (42 U.S.C. 1395w–21(e)(2)) is amended—

(1) in subparagraph (B)(i), by inserting ''and subparagraph (D)'' after ''clause (ii)'';

(2) in subparagraph (C)(i), by inserting ''and subparagraph (D)'' after ''clause (ii)''; and

(3) by adding at the end the following new subparagraph:

''(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—At any time after 2001 in the case of a Medicare+Choice eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)—

''(i) to enroll in a Medicare+Choice plan; or

''(ii) to change the Medicare+Choice plan in which the individual is enrolled.''.

(c) CONTINUING ENROLLMENT FOR CERTAIN ENROLLEES.—Section 1851(b)(1) (42 U.S.C. 1395w–21(b)(1)) is amended—

(1) in subparagraph (A), by inserting ''and except as provided in subparagraph (C)'' after ''may otherwise provide''; and

(2) by adding at the end the following new subparagraph:

''(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a Medicare+Choice organization eliminates from its service area a Medicare+Choice payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in a Medicare+Choice plan it offers so long as—

''(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

''(ii) there is no other Medicare+Choice plan offered in the area in which the enrollee resides at the time of the organization's election.''.

(d) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) apply to notices of impending terminations or discontinuances made on or after the date of the enactment of this Act.

(2) The amendments made by subsection (c) apply to elections made on or after the date of the enactment of this Act with respect to eliminations of Medicare+Choice payment areas from a service area that occur before, on, or after the date of the enactment of this Act.

SEC. 502. CHANGE IN EFFECTIVE DATE OF ELECTIONS AND CHANGES OF ELECTIONS OF MEDICARE+CHOICE PLANS.

(a) OPEN ENROLLMENT.—Section 1851(f)(2) (42 U.S.C. 1395w–21(f)(2)) is amended—

(1) by inserting ''or change'' before ''is made''; and

(2) by inserting '', except that if such election or change is made after the 10th day of any calendar month, then the election or change shall not take effect until the first day of the second calendar month following the date on which the election or change is made'' before the period.

(b) EFFECTIVE DATE.—The amendments made by this section apply to elections and changes of coverage made on or after January 1, 2000.

SEC. 503. 2-YEAR EXTENSION OF MEDICARE COST CONTRACTS.

Section 1876(h)(5)(B) (42 U.S.C. 1395mm(h)(5)(B)) is amended by striking ''2002'' and inserting ''2004''.

Subtitle B—Provisions To Facilitate Implementation of the Medicare+Choice Program

SEC. 511. PHASE-IN OF NEW RISK ADJUSTMENT METHODOLOGY; STUDIES AND REPORTS ON RISK ADJUSTMENT.

(a) PHASE-IN.—Section 1853(a)(3)(C) (42 U.S.C. 1395w–23(a)(3)(C)) is amended—

(1) by redesignating the first sentence as clause (i) with the heading ''IN GENERAL.—'' and appropriate indentation; and

(2) by adding at the end the following new clause:

''(ii) PHASE-IN.—Such risk adjustment methodology shall be implemented in a phased-in manner so that the methodology insofar as it makes adjustments to capitation rates for health status applies to—

''(I) 10 percent of 1/12 of the annual Medicare+Choice capitation rate in 2000 and 2001; and

''(II) not more than 20 percent of such capitation rate in 2002.''.

(b) MEDPAC STUDY AND REPORT.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that evaluates the methodology used by the Secretary of Health and Human Services in developing the risk factors used in adjusting the Medicare+Choice capitation rate paid to Medicare+Choice organizations under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) and includes the issues described in paragraph (2).

(2) ISSUES TO BE STUDIED.—The issues described in this paragraph are the following:

(A) The ability of the average risk adjustment factor applied to a Medicare+Choice plan to explain variations in plans' average per capita medicare costs, as reported by Medicare+Choice plans in the plans' adjusted community rate filings.

(B) The year-to-year stability of the risk factors applied to each Medicare+Choice plan and the potential for substantial changes in payment for small Medicare+Choice plans.

(C) For medicare beneficiaries newly enrolled in Medicare+Choice plans in a given year, the correspondence between the average risk factor calculated from medicare fee-for-service data for those individuals from the period prior to their enrollment in a Medicare+Choice plan and the average risk factor calculated for such individuals during their initial year of enrollment in a Medicare+Choice plan.

(D) For medicare beneficiaries disenrolling from or switching among Medicare+Choice plans in a given year, the correspondence between the average risk factor calculated from data pertaining to the period prior to their disenrollment from a Medicare+Choice plan and the average risk factor calculated from data pertaining to the period after disenrollment.

(E) An evaluation of the exclusion of ''discretionary'' hospitalizations from consideration in the risk adjustment methodology.

(F) Suggestions for changes or improvements in the risk adjustment methodology.

(3) REPORT.—Not later than December 1, 2000, the Commission shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study.

(c) STUDY AND REPORT REGARDING REPORTING OF ENCOUNTER DATA.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on how to reduce the costs and burdens on Medicare+Choice organizations of their complying with reporting requirements for encounter data imposed by the Secretary in establishing and implementing a risk adjustment methodology used in making payments to such organizations under section 1853 of the Social Security Act (42 U.S.C. 1395w–23). The Secretary shall consult with representatives of Medicare+Choice organizations in conducting the study. The study shall address the following issues:

(A) Limiting the number and types of sites of services (that are in addition to inpatient sites) for which encounter data must be reported.

(B) Establishing alternative risk adjustment methods that would require submission of less data.

(C) The potential for Medicare+Choice organizations to misreport, overreport, or underreport prevalence of diagnoses in outpatient sites of care, the potential for increases in payments to Medicare+Choice organizations from changes in Medicare+Choice plan coding practices (commonly known as ''coding creep'') and proposed methods for detecting and adjusting for such variations in diagnosis coding as part of the risk adjustment methodology using encounter data from multiple sites of care.

(D) The impact of such requirements on the willingness of insurers to offer Medicare+Choice MSA plans and options for modifying encounter data reporting requirements to accommodate such plans.

(E) Differences in the ability of Medicare+Choice organizations to report encounter data, and the potential for adverse competitive impacts on group and staff model health maintenance organizations or other integrated providers of care based on data reporting capabilities.

(2) REPORT.—Not later than January 1, 2001, the Secretary shall submit a report to Congress on the study conducted under this subsection, together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.

SEC. 512. ENCOURAGING OFFERING OF MEDICARE+CHOICE PLANS IN AREAS WITHOUT PLANS.

Section 1853 (42 U.S.C. 1395w–23) is amended—

(1) in subsection (a)(1), by striking ''subsections (e) and (f)'' and inserting ''subsections (e), (g), and (i)'';

(2) in subsection (c)(5), by inserting ''(other than those attributable to subsection (i))'' after ''payments under this part''; and

(3) by adding at the end the following new subsection:

''(i) NEW ENTRY BONUS.—

''(1) IN GENERAL.—Subject to paragraphs (2) and (3), in the case of Medicare+Choice payment area in which a Medicare+Choice plan has not been offered since 1997 (or in which all organizations that offered a plan since such date have filed notice with the Secretary, as of October 13, 1999, that they will not be offering such a plan as of January 1, 2000), the amount of the monthly payment otherwise made under this section shall be increased—

''(A) only for the first 12 months in which any Medicare+Choice plan is offered in the area, by

5 percent of the total monthly payment otherwise computed for such payment area; and

''(B) only for the subsequent 12 months, by 3 percent of the total monthly payment otherwise computed for such payment area.

''(2) PERIOD OF APPLICATION.—Paragraph (1) shall only apply to payment for Medicare+Choice plans which are first offered in a Medicare+Choice payment area during the 2-year period beginning on January 1, 2000.

''(3) LIMITATION TO ORGANIZATION OFFERING FIRST PLAN IN AN AREA.—Paragraph (1) shall only apply to payment to the first Medicare+Choice organization that offers a Medicare+Choice plan in each Medicare+Choice payment area, except that if more than one such organization first offers such a plan in an area on the same date, paragraph (1) shall apply to payment for such organizations.

''(4) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as affecting the calculation of the annual Medicare+Choice capitation rate under subsection (c) for any payment area or as applying to payment for any period not described in such paragraph and paragraph (2).

''(5) OFFERED DEFINED.—In this subsection, the term 'offered' means, with respect to a Medicare+Choice plan as of a date, that a Medicare+Choice eligible individual may enroll with the plan on that date, regardless of when the enrollment takes effect or when the individual obtains benefits under the plan.''.

SEC. 513. MODIFICATION OF 5-YEAR RE-ENTRY RULE FOR CONTRACT TERMINATIONS.

(a) REDUCTION OF GENERAL EXCLUSION PERIOD TO 2 YEARS.—Section 1857(c)(4) (42 U.S.C. 1395w–27(c)(4)) is amended by striking ''5-year period'' and inserting ''2-year period''.

(b) SPECIFIC EXCEPTION WHERE CHANGE IN PAYMENT POLICY.—

(1) IN GENERAL.—Section 1857(c)(4) (42 U.S.C. 1395w–27(c)(4)) is amended—

(A) by striking ''except in circumstances'' and inserting ''except as provided in subparagraph (B) and except in such other circumstances'';

(B) by redesignating the sentence following ''(4)'' as a subparagraph (A) with an appropriate indentation and the heading ''IN GENERAL.—''; and

(C) by adding at the end the following new subparagraph:

''(B) EARLIER RE-ENTRY PERMITTED WHERE CHANGE IN PAYMENT POLICY.—Subparagraph (A) shall not apply with respect to the offering by a Medicare+Choice organization of a Medicare+Choice plan in a Medicare+Choice payment area if during the 6-month period beginning on the date the organization notified the Secretary of the intention to terminate the most recent previous contract, there was a legislative change enacted (or a regulatory change adopted) that has the effect of increasing payment amounts under section 1853 for that Medicare+Choice payment area.''.

(2) CONSTRUCTION RELATING TO ADDITIONAL EXCEPTIONS.—Nothing in the amendment made by paragraph (1)(C) shall be construed to affect the authority of the Secretary of Health and Human Services to provide for exceptions in addition to the exception provided in such amendment, including exceptions provided under Operational Policy Letter #103 (OPL99.103).

(c) EFFECTIVE DATE.—The amendments made by this section apply to contract terminations occurring before, on, or after the date of the enactment of this Act.

SEC. 514. CONTINUED COMPUTATION AND PUBLICATION OF MEDICARE ORIGINAL FEE-FOR-SERVICE EXPENDITURES ON A COUNTY-SPECIFIC BASIS.

(a) IN GENERAL.—Section 1853(b) (42 U.S.C. 1395w–23(b)) is amended by adding at the end the following new paragraph:

''(4) CONTINUED COMPUTATION AND PUBLICATION OF COUNTY-SPECIFIC PER CAPITA FEE-FOR-SERVICE EXPENDITURE INFORMATION.—The Secretary, through the Chief Actuary of the Health Care Financing Administration, shall provide for the computation and publication, on an annual basis beginning with 2001 at the time of publication of the annual Medicare+Choice capitation rates under paragraph (1), of the following information for the original medicare fee-for-service program under parts A and B (exclusive of individuals eligible for coverage under section 226A) for each Medicare+Choice payment area for the second calendar year ending before the date of publication:

''(A) Total expenditures per capita per month, computed separately for part A and for part B.

''(B) The expenditures described in subparagraph (A) reduced by the best estimate of the expenditures (such as graduate medical education and disproportionate share hospital payments) not related to the payment of claims.

''(C) The average risk factor for the covered population based on diagnoses reported for medicare inpatient services, using the same methodology as is expected to be applied in making payments under subsection (a).

''(D) Such average risk factor based on diagnoses for inpatient and other sites of service, using the same methodology as is expected to be applied in making payments under subsection (a).''.

(b) SPECIAL RULE FOR 2001.—In providing for the publication of information under section 1853(b)(4) of the Social Security Act (42 U.S.C. 1395w–23(b)(4)), as added by subsection (a), in 2001, the Secretary of Health and Human Services shall also include the information described in such section for 1998, as well as for 1999.

SEC. 515. FLEXIBILITY TO TAILOR BENEFITS UNDER MEDICARE+CHOICE PLANS.

(a) IN GENERAL.—Section 1854 (42 U.S.C. 1395w–24) is amended—

(1) in subsection (a)(1), by inserting ''(or segment of such an area if permitted under subsection (h))'' after ''service area'' in the matter preceding subparagraph (A); and

(2) by adding at the end the following:

''(h) PERMITTING USE OF SEGMENTS OF SERVICE AREAS.—The Secretary shall permit a Medicare+Choice organization to elect to apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are composed of one or more Medicare+Choice payment areas.''.

(b) EFFECTIVE DATE.—The amendments made by this section apply to contract years beginning on or after January 1, 2001.

SEC. 516. DELAY IN DEADLINE FOR SUBMISSION OF ADJUSTED COMMUNITY RATES.

(a) DELAY IN DEADLINE FOR SUBMISSION OF ADJUSTED COMMUNITY RATES.—Section 1854(a)(1) (42 U.S.C. 1395w–24(a)(1)) is amended by striking ''May 1'' and inserting ''July 1'' in the matter preceding subparagraph (A).

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to information submitted by Medicare+Choice organizations for years beginning with 1999.

SEC. 517. REDUCTION IN ADJUSTMENT IN NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE FOR 2002.

Section 1853(c)(6)(B)(v) (42 U.S.C. 1395w–23(c)(6)(B)(v)) is amended by striking ''0.5 percentage points'' and inserting ''0.3 percentage points''.

SEC. 518. DEEMING OF MEDICARE+CHOICE ORGANIZATION TO MEET REQUIREMENTS.

Section 1852(e)(4) (42 U.S.C. 1395w–22(e)(4)) is amended to read as follows:

''(4) TREATMENT OF ACCREDITATION.—

''(A) IN GENERAL.—The Secretary shall provide that a Medicare+Choice organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1856 to carry out the requirements in such clause.

''(B) REQUIREMENTS DESCRIBED.—The provisions described in this subparagraph are the following:

''(i) Paragraphs (1) and (2) of this subsection (relating to quality assurance programs).

''(ii) Subsection (b) (relating to antidiscrimination).

''(iii) Subsection (d) (relating to access to services).

''(iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).

''(v) Subsection (i) (relating to information on advance directives).

''(vi) Subsection (j) (relating to provider participation rules).

''(C) TIMELY ACTION ON APPLICATIONS.—The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1865(b)(2), whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

''(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1857, including the authority to terminate contracts with Medicare+Choice organizations under subsection (c)(2) of such section.''.

SEC. 519. TIMING OF MEDICARE+CHOICE HEALTH INFORMATION FAIRS.

(a) IN GENERAL.—Section 1851(e)(3)(C) (42 U.S.C. 1395w–21(e)(3)(C)) is amended by striking ''In the month of November'' and inserting ''During the fall season''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) first applies to campaigns conducted beginning in 2000.

SEC. 520. QUALITY ASSURANCE REQUIREMENTS FOR PREFERRED PROVIDER ORGANIZATION PLANS.

(a) IN GENERAL.—Section 1852(e)(2) (42 U.S.C. 1395w–22(e)(2)) is amended—

(1) in subparagraph (A), by striking ''or a non-network MSA plan'' and inserting '', a non-network MSA plan, or a preferred provider organization plan';

(2) in subparagraph (B)—

(A) in the heading, by striking ''AND NON-NETWORK MSA PLANS'' and inserting '', NON-NETWORK MSA PLANS, AND PREFERRED PROVIDER ORGANIZATION PLANS''; and

(B) by striking ''or a non-network MSA plan'' and inserting '', a non-network MSA plan, or a preferred provider organization plan'';

(3) by adding at the end the following:

''(D) DEFINITION OF PREFERRED PROVIDER ORGANIZATION PLAN.—In this paragraph, the term 'preferred provider organization plan' means a Medicare+Choice plan that—

''(i) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

''(ii) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

''(iii) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to contract years beginning on or after January 1, 2000.

(c) QUALITY IMPROVEMENT STANDARDS.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the appropriate quality improvement standards that should apply to—

(A) each type of Medicare+Choice plan described in section 1851(a)(2) of the Social Security Act (42 U.S.C. 1395w–21(a)(2)), including each type of Medicare+Choice plan that is a coordinated care plan (as described in subparagraph (A) of such section); and

(B) the original medicare fee-for-service program under parts A and B title XVIII of such Act (42 U.S.C. 1395 et seq.).

(2) CONSIDERATIONS.—Such study shall specifically examine the effects, costs, and feasibility of requiring entities, physicians, and other health care providers that provide items and services under the original medicare fee-for-service program to comply with quality standards and related reporting requirements that are comparable to the quality standards and related reporting requirements that are applicable to Medicare+Choice organizations.

(3) REPORT.—Not later than 2 years after the date of the enactment of this Act, such Commission shall submit a report to Congress on the study conducted under this subsection, together with any recommendations for legislation that it determines to be appropriate as a result of such study.

SEC. 521. CLARIFICATION OF NONAPPLICABILITY OF CERTAIN PROVISIONS OF DISCHARGE PLANNING PROCESS TO MEDICARE+CHOICE PLANS.

Section 1861(ee) (42 U.S.C. 1395x(ee)(2)(H)) is amended by adding at the end the following:

''(3) With respect to a discharge plan for an individual who is enrolled with a Medicare+Choice organization under a Medicare+Choice plan and is furnished inpatient hospital services by a hospital under a contract with the organization—

''(A) the discharge planning evaluation under paragraph (2)(D) is not required to include information on the availability of home health services through individuals and entities which do not have a contract with the organization; and

''(B) notwithstanding subparagraph (H)(i), the plan may specify or limit the provider (or providers) of post-hospital home health services or other post-hospital services under the plan.''.

SEC. 522. USER FEE FOR MEDICARE+CHOICE ORGANIZATIONS BASED ON NUMBER OF ENROLLED BENEFICIARIES.

(a) IN GENERAL.—Section 1857(e)(2) (42 U.S.C. 1395w–27(e)(2)) is amended—

(1) in subparagraph (B), by striking ''Any amounts collected are authorized to be appropriated only for'' and inserting ''Any amounts collected shall be available without further appropriation to the Secretary for'';

(2) by amending subparagraph (C) to read as follows:

''(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the purposes described in subparagraph (B) for each fiscal year beginning with fiscal year 2001 an amount equal to $100,000,000, reduced by the amount of fees authorized to be collected under this paragraph for the fiscal year.'';

(3) in subparagraph (D)(ii)—

(A) in subclause (II), by striking ''and'';

(B) in subclause (III), by striking '' and each subsequent fiscal year.'' and inserting ''; and''; and

(C) by adding at the end the following:

''(IV) the Medicare+Choice portion (as defined in subparagraph (E)) of $100,000,000 in fiscal year 2001 and each succeeding fiscal year.''; and

(4) by adding at the end the following:

''(E) MEDICARE+CHOICE PORTION DEFINED.—In this paragraph, the term 'Medicare+Choice portion' means, for a fiscal year, the ratio, as estimated by the Secretary, of—

''(i) the average number of individuals enrolled in Medicare+Choice plans during the fiscal year, to

''(ii) the average number of individuals entitled to benefits under part A, and enrolled under part B, during the fiscal year.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to fees charged on or after January 1, 2001. The Secretary of Health and Human Services may not increase the fees charged under section 1857(e)(2) of the Social Security Act (42 U.S.C. 1395w–27(e)(2)) for the 3-month period beginning with October 2000 above the level in effect during the previous 9-month period.

SEC. 523. CLARIFICATION REGARDING THE ABILITY OF A RELIGIOUS FRATERNAL BENEFIT SOCIETY TO OPERATE ANY MEDICARE+CHOICE PLAN.

Section 1859(e)(2) (42 U.S.C. 1395w–29(e)(2)) is amended in the matter preceding subparagraph (A) by striking ''section 1851(a)(2)(A)'' and inserting ''section 1851(a)(2)''.

SEC. 524. RULES REGARDING PHYSICIAN REFERRALS FOR MEDICARE+CHOICE PROGRAM.

(a) IN GENERAL.—Section 1877(b)(3) (42 U.S.C. 1395nn(b)(3)) is amended—

(1) in subparagraph (C), by striking ''or'' at the end;

(3) by adding at the end the following:

(2) in subparagraph (D), by striking the period at the end and inserting '', or''; and

''(E) that is a Medicare+Choice organization under part C that is offering a coordinated care plan described in section 1851(a)(2)(A) to an individual enrolled with the organization.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after the date of the enactment of this Act.

Subtitle C—Demonstration Projects and Special Medicare Populations

SEC. 531. EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION (SHMO) PROJECT AUTHORITY.

(a) EXTENSION.—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203) is amended—

(1) in paragraph (1), by striking ''December 31, 2000'' and inserting ''the date that is 18 months after the date that the Secretary submits to Congress the report described in section 4014(c) of the Balanced Budget Act of 1997'';

(2) in paragraph (4), by striking ''March 31, 2001'' and inserting ''the date that is 21 months after the date on which Secretary submits to Congress the report described in section 4014(c) of the Balanced Budget Act of 1997''; and

(3) by adding at the end of paragraph (4) the following: ''Not later than 6 months after the date the Secretary submits such final report, the Medicare Payment Advisory Commission shall submit to Congress a report containing recommendations regarding such project.''.

(b) SUBSTITUTION OF AGGREGATE CAP.—Section 13567(c) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66) is amended to read as follows:

''(c) AGGREGATE LIMIT ON NUMBER OF MEMBERS.—The Secretary of Health and Human Services may not impose a limit on the number of individuals that may participate in a project conducted under section 2355 of the Deficit Reduction Act of 1984, other than an aggregate limit of not less than 324,000 for all sites.''.

SEC. 532. EXTENSION OF MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECT.

(a) EXTENSION.—Notwithstanding any other provision of law, any demonstration project conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–123; 42 U.S.C. 1395mm note) and conducted for the additional period of 2 years as provided for under section 4019 of BBA, shall be conducted for an additional period of 2 years. The Secretary of Health and Human Services shall provide for such reduction in payments under such project in the extension period provided under the previous sentence as the Secretary determines is necessary to ensure that total Federal expenditures during the extension period under the project do not exceed the total Federal expenditures that would have been made under title XVIII of the Social Security Act if such project had not been so extended.

(b) REPORT.—Not later than July 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report describing the results of any demonstration project conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987, and describing the data collected by the Secretary relevant to the analysis of the results of such project, including the most recently available data through the end of 2000.

SEC. 533. MEDICARE+CHOICE COMPETITIVE BIDDING DEMONSTRATION PROJECT.

Section 4011 of BBA (42 U.S.C. 1395w–23 note) is amended—

(1) in subsection (a)—

(A) by striking ''The Secretary'' and inserting the following (and conforming the indentation for the remainder of the subsection accordingly):

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary''; and

(B) by adding at the end the following:

''(2) DELAY IN IMPLEMENTATION.—The Secretary shall not implement the project until January 1, 2002, or, if later, 6 months after the date the Competitive Pricing Advisory Committee has submitted to Congress a report on each of the following topics:

''(A) INCORPORATION OF ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM INTO PROJECT.—What changes would be required in the project to feasibly incorporate the original medicare fee-for-service program into the project in the areas in which the project is operational.

''(B) QUALITY ACTIVITIES.—The nature and extent of the quality reporting and monitoring activities that should be required of plans participating in the project, the estimated costs that plans will incur as a result of these requirements, and the current ability of the Health Care Financing Administration to collect and report comparable data, sufficient to support comparable quality reporting and monitoring activities with respect to beneficiaries enrolled in the original medicare fee-for-service program generally.

''(C) RURAL PROJECT.—The current viability of initiating a project site in a rural area, given the site specific budget neutrality requirements of the project under subsection (g), and insofar as the Committee decides that the addition of such a site is not viable, recommendations on how the project might best be changed so that such a site is viable.

''(D) BENEFIT STRUCTURE.—The nature and extent of the benefit structure that should be required of plans participating in the project, the rationale for such benefit structure, the potential implications that any benefit standardization requirement may have on the number of plan choices available to a beneficiary in an area designated under the project, the potential implications of requiring participating plans to offer variations on any standardized benefit package the committee might recommend, such that a beneficiary could elect to pay a higher percentage of out-of-pocket costs in exchange for a lower premium (or premium rebate as the case may be), and the potential implications of expanding the project (in conjunction with the potential inclusion of the original medicare fee-for-service program) to require medicare supplemental insurance plans operating in an area designated under the project to offer a coordinated and comparable standardized benefit package.

''(3) CONFORMING DEADLINES.—Any dates specified in the succeeding provisions of this section shall be delayed (as specified by the Secretary) in a manner consistent with the delay effected under paragraph (2).''; and

(2) in subsection (c)(1)(A)—

(A) by striking ''and'' at the end of clause (i); and

(B) by adding at the end the following new clause:

''(iii) establish beneficiary premiums for plans offered in such area in a manner such that a beneficiary who enrolls in an offered plan the per capita bid for which is less than the standard per capita government contribution (as established by the competitive pricing methodology established for such area) may, at the plan's election, be offered a rebate of some or all of the medicare part B premium that such individual must otherwise pay in order to participate in a Medicare+Choice plan under the Medicare+Choice program; and''.

SEC. 534. EXTENSION OF MEDICARE MUNICIPAL HEALTH SERVICES DEMONSTRATION PROJECTS.

Section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 6135 of the Omnibus Budget Reconciliation Act of 1989, section 13557 of the Omnibus Budget Reconciliation Act of 1993, and section 4017 of BBA, is amended by striking ''December 31, 2000'' and inserting ''December 31, 2002''.

SEC. 535. MEDICARE COORDINATED CARE DEMONSTRATION PROJECT.

Section 4016(e)(1)(A)(ii) of BBA (42 U.S.C. 1395b–1 note) is amended to read as follows:

''(ii) CANCER HOSPITAL.—In the case of the project described in subsection (b)(2)(C), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t), in such proportions as the Secretary determines to be appropriate, of such funds as are necessary to cover costs of the project, including costs for information infrastructure and recurring costs of case management services, flexible benefits, and program management.''.

SEC. 536. MEDIGAP PROTECTIONS FOR PACE PROGRAM ENROLLEES.

(a) IN GENERAL.—Section 1882(s)(3)(B) (42 U.S.C. 1395ss(s)(3)(B)) is amended—

(1) in clause (ii), by inserting ''or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1894, and there are circumstances that would permit the discontinuance of the individual's enrollment with such provider under circumstances that are similar to the circumstances that would permit discontinuance of the individual's election under the first sentence of such section if such individual were enrolled in a Medicare+Choice plan'' before the period;

(2) in clause (v)(II), by inserting ''any PACE provider under section 1894,'' after ''demonstration project authority,''; and

(3) in clause (vi)—

(A) by inserting ''or in a PACE program under section 1894'' after ''part C''; and

(B) by striking ''such plan'' and inserting ''such plan or such program''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to terminations or discontinuances made on or after the date of the enactment of this Act.

Subtitle D—Medicare+Choice Nursing and Allied Health Professional Education Payments

SEC. 541. MEDICARE+CHOICE NURSING AND ALLIED HEALTH PROFESSIONAL EDUCATION PAYMENTS.

(a) ADDITIONAL PAYMENTS FOR NURSING AND ALLIED HEALTH EDUCATION.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(l) PAYMENT FOR NURSING AND ALLIED HEALTH EDUCATION FOR MANAGED CARE ENROLLEES.—

''(1) IN GENERAL.—For portions of cost reporting periods occurring in a year (beginning with 2000), the Secretary shall provide for an additional payment amount for any hospital that receives payments for the costs of approved educational activities for nurse and allied health professional training under section 1861(v)(1).

''(2) PAYMENT AMOUNT.—The additional payment amount under this subsection for each hospital for portions of cost reporting periods occurring in a year shall be an amount specified by the Secretary in a manner consistent with the following:

''(A) DETERMINATION OF MANAGED CARE ENROLLEE PAYMENT RATIO FOR GRADUATE MEDICAL EDUCATION PAYMENTS.—The Secretary shall estimate the ratio of payments for all hospitals for portions of cost reporting periods occurring in the year under subsection (h)(3)(D) to total direct graduate medical education payments estimated for such portions of periods under subsection (h)(3).

''(B) APPLICATION TO FEE-FOR-SERVICE NURSING AND ALLIED HEALTH EDUCATION PAYMENTS.—Such ratio shall be applied to the Secretary's estimate of total payments for nursing and allied health education determined under section 1861(v) for portions of cost reporting periods occurring in the year to determine a total amount of additional payments for nursing and allied health education to be distributed to hospitals under this subsection for portions of cost reporting periods occurring in the year; except that in no case shall such total amount exceed $60,000,000 in any year.

''(C) APPLICATION TO HOSPITAL.—The amount of payment under this subsection to a hospital for portions of cost reporting periods occurring in a year is equal to the total amount of payments determined under subparagraph (B) for the year multiplied by the Secretary's estimate of the ratio of the amount of payments made under section 1861(v) to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the second preceding fiscal year to the total of such amounts for all hospitals for such cost reporting periods.''.

(b) ADJUSTMENTS IN PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(3)(D) (42 U.S.C. 1395ww(h)(3)(D)) is amended—

(1) in clause (i), by inserting '', subject to clause (iii),'' after ''shall equal'';

(2) by redesignating clause (iii) as clause (iv); and

(3) by inserting after clause (ii) the following new clause:

''(iii) PROPORTIONAL REDUCTION FOR NURSING AND ALLIED HEALTH EDUCATION.—The Secretary shall estimate a proportional adjustment in payments to all hospitals determined under clauses (i) and (ii) for portions of cost reporting periods beginning in a year (beginning with 2000) such that the proportional adjustment reduces payments in an amount for such year equal to the total additional payment amounts for nursing and allied health education determined under subsection (l) for portions of cost reporting periods occurring in that year.''.

Subtitle E—Studies and Reports

SEC. 551. REPORT ON ACCOUNTING FOR VA AND DOD EXPENDITURES FOR MEDICARE BENEFICIARIES.

Not later April 1, 2001, the Secretary of Health and Human Services, jointly with the Secretaries of Defense and of Veterans Affairs, shall submit to Congress a report on the estimated use of health care services furnished by the Departments of Defense and of Veterans Affairs to medicare beneficiaries, including both beneficiaries under the original medicare fee-for-service program and under the Medicare+Choice program. The report shall include an analysis of how best to properly account for expenditures for such services in the computation of Medicare+Choice capitation rates.

SEC. 552. MEDICARE PAYMENT ADVISORY COMMISSION STUDIES AND REPORTS.

(a) DEVELOPMENT OF SPECIAL PAYMENT RULES UNDER THE MEDICARE+CHOICE PROGRAM FOR FRAIL ELDERLY ENROLLED IN SPECIALIZED PROGRAMS.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the development of a payment methodology under the Medicare+Choice program for frail elderly Medicare+Choice beneficiaries enrolled in a Medicare+Choice plan under a specialized program for the frail elderly that—

(A) accounts for the prevalence, mix, and severity of chronic conditions among such frail elderly Medicare+Choice beneficiaries;

(B) includes medical diagnostic factors from all provider settings (including hospital and nursing facility settings); and

(C) includes functional indicators of health status and such other factors as may be necessary to achieve appropriate payments for plans serving such beneficiaries.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Commission shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study.

(b) REPORT ON MEDICARE MSA (MEDICAL SAVINGS ACCOUNT) PLANS.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Assessment Commission shall submit to Congress a report on specific legislative changes that should be made to make MSA plans (as defined in section 1859(b)(3) of the Social Security Act, 42 U.S.C. 1395w–29(b)(3)) a viable option under the Medicare+Choice program.

SEC. 553. GAO STUDIES, AUDITS, AND REPORTS.

(a) STUDY OF MEDIGAP POLICIES.—

(1) IN GENERAL.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study of the issues described in paragraph (2) regarding medicare supplemental policies described in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1)).

(2) ISSUES TO BE STUDIED.—The issues described in this paragraph are the following:

(A) The level of coverage provided by each type of medicare supplemental policy.

(B) The current enrollment levels in each type of medicare supplemental policy.

(C) The availability of each type of medicare supplemental policy to medicare beneficiaries over age 65½.

(D) The number and type of medicare supplemental policies offered in each State.

(E) The average out-of-pocket costs (including premiums) per beneficiary under each type of medicare supplemental policy.

(2) REPORT.—Not later than July 31, 2001, the Comptroller General shall submit a report to Congress on the results of the study conducted under this subsection, together with any recommendations for legislation that the Comptroller General determines to be appropriate as a result of such study.

(b) GAO AUDIT AND REPORTS ON THE PROVISION OF MEDICARE+CHOICE HEALTH INFORMATION TO BENEFICIARIES.—

(1) IN GENERAL.—Beginning in 2000, the Comptroller General shall conduct an annual audit of the expenditures by the Secretary of Health and Human Services during the preceding year in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) to eligible medicare beneficiaries.

(3) REPORTS.—Not later than March 31 of 2001, 2004, 2007, and 2010, the Comptroller General shall submit a report to Congress on the results of the audit of the expenditures of the preceding 3 years conducted pursuant to subsection (a), together with an evaluation of the effectiveness of the means used by the Secretary of Health and Human Services in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) to eligible medicare beneficiaries.

TITLE VI—MEDICAID

SEC. 601. INCREASE IN DSH ALLOTMENT FOR CERTAIN STATES AND THE DISTRICT OF COLUMBIA.

(a) IN GENERAL.—The table in section 1923(f)(2) (42 U.S.C. 1396r–4(f)(2)) is amended under each of the columns for FY 00, FY 01, and FY 02—

(1) in the entry for the District of Columbia, by striking ''23'' and inserting ''32'';

(2) in the entry for Minnesota, by striking ''16'' and inserting ''33'';

(3) in the entry for New Mexico, by striking ''5'' and inserting ''9''; and

(4) in the entry for Wyoming, by striking ''0'' and inserting ''0.1''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on October 1, 1999, and applies to expenditures made on or after such date.

SEC. 602. REMOVAL OF FISCAL YEAR LIMITATION ON CERTAIN TRANSITIONAL ADMINISTRATIVE COSTS ASSISTANCE.

(a) IN GENERAL.—Section 1931(h) (42 U.S.C. 1396u–1(h)) is amended—

(1) in paragraph (3), by striking ''and ending with fiscal year 2000''; and

(2) by striking paragraph (4).

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 114 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2177).

SEC. 603. MODIFICATION OF THE PHASE-OUT OF PAYMENT FOR FEDERALLY-QUALIFIED HEALTH CENTER SERVICES AND RURAL HEALTH CLINIC SERVICES BASED ON REASONABLE COSTS.

(a) MODIFICATION OF PHASE-OUT.—

(1) IN GENERAL.—Section 1902(a)(13)(C)(i) (42 U.S.C. 1396a(a)(13)(C)(i)) is amended by striking ''90 percent for services furnished during fiscal year 2001, 85 percent for services furnished during fiscal year 2002, or 70 percent for services furnished during fiscal year 2003'' and inserting ''fiscal year 2001, or fiscal year 2002, 90 percent for services furnished during fiscal year 2003, or 85 percent for services furnished during fiscal year 2004''.

(2) CONFORMING AMENDMENT TO END OF TRANSITIONAL PAYMENT RULES.—Section 4712(c) of BBA (111 Stat. 509) is amended by striking ''2003'' and inserting ''2004''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect as if included in the enactment of section 4712 of BBA (111 Stat. 508).

(b) GAO STUDY AND REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit a report to Congress that evaluates the effect on Federally-qualified health centers and rural health clinics and on the populations served by such centers and clinics of the phase-out and elimination of the reasonable cost basis for payment for Federally-qualified health center services and rural health clinic services provided under section 1902(a)(13)(C)(i) of the Social Security Act (42 U.S.C. 1396a(a)(13)(C)(i)), as amended by section 4712 of BBA (111 Stat. 508) and subsection (a) of this section. Such report shall include an analysis of the amount, method, and impact of payments made by States that have provided for payment under title XIX of such Act for such services on a basis other than payment of costs which are reasonable and related to the cost of furnishing such services, together with any recommendations for legislation, including whether a new payment system is needed, that the Comptroller General determines to be appropriate as a result of the study.

SEC. 604. PARITY IN REIMBURSEMENT FOR CERTAIN UTILIZATION AND QUALITY CONTROL SERVICES; ELIMINATION OF DUPLICATIVE REQUIREMENTS FOR EXTERNAL QUALITY REVIEW OF MEDICAID MANAGED CARE ORGANIZATIONS.

(a) PARITY IN REIMBURSEMENT FOR CERTAIN UTILIZATION AND QUALITY CONTROL SERVICES.—

(1) INTERIM AMENDMENT TO REMOVE REFERENCES TO QUALITY REVIEW.—Section 1902(d) (42 U.S.C. 1396a(d)) is amended by striking ''for the performance of the quality review functions described in subsection (a)(30)(C),''.

(2) FINAL AMENDMENTS TO REMOVE REFERENCES TO QUALITY REVIEW.—

(A) SECTION 1902.—Section 1902(d) (42 U.S.C. 1396a(d)) is amended by striking ''(including quality review functions described in subsection (a)(30)(C))''.

(B) SECTION 1903.—Section 1903(a)(3)(C)(i) (42 U.S.C. 1396b(a)(3)(C)(i)) is amended by striking ''or quality review''.

(b) ELIMINATION OF DUPLICATIVE REQUIREMENTS FOR EXTERNAL QUALITY REVIEW OF MEDICAID MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1902(a)(30) (42 U.S.C. 1396a(a)(30)) is amended—

(A) in subparagraph (A), by adding ''and'' at the end;

(B) in subparagraph (B)(ii), by striking ''and'' at the end; and

(C) by striking subparagraph (C).

(2) CONFORMING AMENDMENT.—Section 1903(m)(6)(B) (42 U.S.C. 1396b(m)(6)(B)) is amended—

(A) in clause (ii), by adding ''and'' at the end;

(B) in clause (iii), by striking ''; and'' and inserting a period; and

(C) by striking clause (iv).

(c) EFFECTIVE DATES.—

(1) The amendment made by subsection (a)(1) applies to expenditures made on and after the date of the enactment of this Act.

(2) The amendments made by subsections (a)(2) and (b) apply as of such date as the Secretary of Health and Human Services certifies to Congress that the Secretary is fully implementing section 1932(c)(2) of the Social Security Act (42 U.S.C. 1396u–2(c)(2)).

SEC. 605. INAPPLICABILITY OF ENHANCED MATCH UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM TO MEDICAID DSH PAYMENTS.

(a) IN GENERAL.—The last sentence of section 1905(b) (42 U.S.C. 1396d(b)) is amended by inserting ''(other than expenditures under section 1923)'' after ''with respect to expenditures''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on October 1, 1999, and applies to expenditures made on or after such date.

SEC. 606. OPTIONAL DEFERMENT OF THE EFFECTIVE DATE FOR OUTPATIENT DRUG AGREEMENTS.

(a) IN GENERAL.—Section 1927(a)(1) (42 U.S.C. 1396r–8(a)(1)) is amended by striking ''shall not be effective until'' and inserting ''shall become effective as of the date on which the agreement is entered into or, at State option, on any date thereafter on or before''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to agreements entered into on or after the date of enactment of this Act.

SEC. 607. MAKING MEDICAID DSH TRANSITION RULE PERMANENT.

(a) IN GENERAL.—Section 4721(e) of BBA (42 U.S.C. 1396r–4 note) is amended—

(1) in the matter before paragraph (1), by striking ''1923(g)(2)(A)'' and ''1396r–4(g)(2)(A)'' and inserting ''1923(g)(2)'' and ''1396r–4(g)(2)'', respectively;

(2) in paragraphs (1) and (2)—

(A) by striking '', and before July 1, 1999''; and

(B) by striking ''in such section'' and inserting ''in subparagraph (A) of such section''; and

(3) by striking ''and'' at the end of paragraph (1), by striking the period at the end of paragraph (2) and inserting ''; and'', and by adding at the end the following new paragraph:

''(3) effective for State fiscal years that begin on or after July 1, 1999, 'or (b)(1)(B)' were inserted in section 1923(g)(2)(B)(ii)(I) after '(b)(1)(A)'.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of section 4721(e) of BBA.

SEC. 608. MEDICAID TECHNICAL CORRECTIONS.

(a) Section 1902(a)(64) (42 U.S.C. 1396a(a)(64)) is amended by adding ''and'' at the end.

(b) Section 1902(j) (42 U.S.C. 1396a(j)) is amended by striking ''of of'' and inserting ''of''.

(c) Section 1902(l) (42 U.S.C. 1396a(l)) is amended—

(1) in paragraph (1)(C), by striking ''children children'' and inserting ''children'';

(2) in paragraph (3), in the matter preceding subparagraph (A), by striking the first comma after ''(a)(10)(A)(i)(VII)''; and

(3) in paragraph (4)(B), by inserting a comma after ''(a)(10)(A)(i)(IV)''.

(d) Section 1902(v) (42 U.S.C. 1396a(v)) is amended by striking ''(1)''.

(e) Section 1903(b)(4) (42 U.S.C. 1396b(b)(4)) is amended, in the matter preceding subparagraph (A), by inserting ''of'' after ''for the use''.

(f) The left margins of clauses (i) and (ii) of section 1903(d)(3)(B) (42 U.S.C. 1396b(d)(3)(B)) are each realigned so as to align with the left margin of section 1903(d)(3)(A).

(g) Section 1903(f)(2) (42 U.S.C. 1396b(f)(2)) is amended by striking the extra period at the end.

(h) Section 1903(i)(14) (1396b(i)(14)) is amended by adding ''or'' after the semicolon.

(i) Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended—

(1) in clause (vi), by striking the semicolon the first place it appears; and

(2) by redesignating the clause (xi) added by section 4701(c)(3) of BBA (111 Stat. 493) as clause (xii).

(j) Section 1903(o) (42 U.S.C. 1396b(o)) is amended by striking ''1974))'' and inserting ''1974)''.

(k) Section 1903(w) (42 U.S.C. 1396b(w)) is amended—

(1) in paragraph (1)(B), by striking ''puroses'' and inserting ''purposes'';

(2) in paragraph (3)(B), by inserting a comma after ''(D)''; and

(3) by realigning the left margin of clause (viii) in paragraph (7)(A) so as to align with the left margin of clause (vii) of that paragraph.

(l) Section 1905(b)(1) (42 U.S.C. 1396d(b)(1)) is amended by striking ''per centum,,'' and inserting ''per centum,''.

(m) Section 1905(l)(2)(B) (42 U.S.C. 1936d(l)(2)(B)) is amended by striking ''a entity'' and inserting ''an entity''.

(n) The heading for section 1910 (42 U.S.C. 1396i) is amended by striking ''OF'' the first place it appears.

(o) Section 1915 (42 U.S.C. 1396n) is amended—

(1) in subsection (b), by striking ''1902(a)(13)(E)'' and inserting ''1902(a)(13)(C)'';

(2) in the last sentence of subsection (d)(5)(B)(iii), by striking ''75'' and inserting ''65''; and

(3) in subsection (h), by striking ''90 day'' and inserting ''90 days''.

(p) Section 1919 (42 U.S.C. 1396r) is amended—

(1) in subsection (b)(3)(C)(i)(I), by striking ''not later than'' the first place it appears; and

(2) in subsection (d)(4)(A), by striking ''1124'' and inserting ''1124)''.

(q) Section 1920(b)(2)(D)(i)(I) (42 U.S.C. 1396r–1(b)(2)(D)(i)(I)) is amended by striking ''329, 330, or 340'' and inserting ''330 or 330A''.

(r) Section 1920A(d)(1)(B) (42 U.S.C. 1396r–1a(d)(1)(B)) is amended by striking ''a entity'' and inserting ''an entity''.

(s) Section 1923(c)(3)(B) (42 U.S.C. 1396r–4(c)(3)(B)) is amended by striking ''patients.'' and inserting ''patients,''.

(t) Section 1925 (42 U.S.C. 1396r–6) is amended—

(1) in subsection (a)(3)(C), by striking ''(i)(VI) (i)(VII),,'' and inserting ''(i)(VI), (i)(VII),''; and

(2) in subsection (b)(3)(C)(i), by striking ''(i)(IV) (i)(VI) (i)(VII),,'' and inserting ''(i)(IV), (i)(VI), (i)(VII),''.

(u) Section 1927 (42 U.S.C. 1396r–8) is amended—

(1) in subsection (g)(2)(A)(ii)(II)(cc), by striking ''individuals'' and inserting ''individual's'';

(2) in subsection (i)(1), by striking ''the the'' and inserting ''the''; and

(3) in subsection (k)(7)—

(A) in subparagraph (A)(iv), by striking ''distributers'' and inserting ''distributors''; and

(B) in subparagraph (C)(i), by striking ''pharmaceuutically'' and inserting ''pharmaceutically''.

(v) Section 1929 (42 U.S.C. 1396t) is amended—

(1) in subsection (c)(2), by realigning the left margins of clauses (i) and (ii) of subparagraph (E) so as to align with the left margins of clauses (i) and (ii) of subparagraph (F) of that subsection;

(2) in subsection (k)(1)(A)(i), by striking ''settings,'' and inserting ''settings),''; and

(3) in subsection (l), by striking ''State wideness'' and inserting ''Statewideness''.

(w) Section 1932 (42 U.S.C. 1396u–2) is amended—

(1) in subsection (c)(2)(C), by inserting ''part'' before ''C of title XVIII''; and

(2) in subsection (d)—

(A) in paragraph (1)(C)(ii), by striking ''Act'' and inserting ''Regulation''; and

(B) in paragraph (2)(B), by striking ''1903(t)(3)'' and inserting ''1905(t)(3)''.

(x) Section 1933(b)(4) (42 U.S.C. 1396u–3(b)(4)) is amended by inserting ''a'' after ''for a month in''.

(y)(1) The section 1908 (42 U.S.C. 1396g–1) that relates to required laws relating to medical child support is redesignated as section 1908A.

(2) Section 1902(a)(60) (42 U.S.C. 1396b(a)(60)) is amended by striking ''1908'' and inserting ''1908A''.

(z) Effective October 1, 2004, section 1915(b) (42 U.S.C. 1396n(b)) is amended, in the matter preceding paragraph (1), by striking ''sections 1902(a)(13)(C) and'' and inserting ''section''.

(aa) Effective as if included in the enactment of BBA—

(1) section 1902(a)(10)(A)(ii)(XIV) (42 U.S.C. 1396a(a)(10)(A)(ii)(XIV)) is amended by striking ''1905(u)(2)(C)'' and inserting ''1905(u)(2)(B)'';

(2) section 1903(f)(4) (42 U.S.C. 1396b(f)(4)) is amended, in the matter preceding subparagraph (A), by striking ''1905(p)(1), or 1905(u)'' and inserting ''1902(a)(10)(A)(ii)(XIII), 1902(a)(10)(A)(ii)(XIV), or 1905(p)(1)''; and

(3) section 1905(a)(15) (42 U.S.C. 1396d(a)(15)) is amended by striking ''1902(a)(31)(A)'' and inserting ''1902(a)(31)''.

(bb) Except as otherwise provided, the amendments made by this section shall take effect on the date of enactment of this Act.

TITLE VII—STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

SEC. 701. STABILIZING THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM ALLOTMENT FORMULA.

(a) IN GENERAL.—Section 2104(b) (42 U.S.C. 1397dd(b)) is amended—

(1) in paragraph (2)(A)—

(A) in clause (i), by striking ''through 2000'' and inserting ''and 1999''; and

(B) in clause (ii), by striking ''2001'' and inserting ''2000'';

(2) by amending paragraph (4) to read as follows:

''(4) FLOORS AND CEILINGS IN STATE ALLOTMENTS.—

''(A) IN GENERAL.—The proportion of the allotment under this subsection for a subsection (b) State (as defined in subparagraph (D)) for fiscal year 2000 and each fiscal year thereafter shall be subject to the following floors and ceilings:

''(i) FLOOR OF $2,000,000.—A floor equal to $2,000,000 divided by the total of the amount available under this subsection for all such allotments for the fiscal year.

''(ii) ANNUAL FLOOR OF 10 PERCENT BELOW PRECEDING FISCAL YEAR'S PROPORTION.—A floor of 90 percent of the proportion for the State for the preceding fiscal year.

''(iii) CUMULATIVE FLOOR OF 30 PERCENT BELOW THE FY 1999 PROPORTION.—A floor of 70 percent of the proportion for the State for fiscal year 1999.

''(iv) CUMULATIVE CEILING OF 45 PERCENT ABOVE FY 1999 PROPORTION.—A ceiling of 145 percent of the proportion for the State for fiscal year 1999.

''(B) RECONCILIATION.—

''(i) ELIMINATION OF ANY DEFICIT BY ESTABLISHING A PERCENTAGE INCREASE CEILING FOR STATES WITH HIGHEST ANNUAL PERCENTAGE INCREASES.—To the extent that the application of subparagraph (A) would result in the sum of the proportions of the allotments for all subsection (b) States exceeding 1.0, the Secretary shall establish a maximum percentage increase in such proportions for all subsection (b) States for the fiscal year in a manner so that such sum equals 1.0.

''(ii) ALLOCATION OF SURPLUS THROUGH PRO RATA INCREASE.—To the extent that the application of subparagraph (A) would result in the sum of the proportions of the allotments for all subsection (b) States being less than 1.0, the proportions of such allotments (as computed before the application of floors under clauses (i), (ii), and (iii) of subparagraph (A)) for all subsection (b) States shall be increased in a pro rata manner (but not to exceed the ceiling established under subparagraph (A)(iv)) so that (after the application of such floors and ceiling) such sum equals 1.0.

''(C) CONSTRUCTION.—This paragraph shall not be construed as applying to (or taking into account) amounts of allotments redistributed under subsection (f).

''(D) DEFINITIONS.—In this paragraph:

''(i) PROPORTION OF ALLOTMENT.—The term 'proportion' means, with respect to the allotment of a subsection (b) State for a fiscal year, the amount of the allotment of such State under this subsection for the fiscal year divided by the total of the amount available under this subsection for all such allotments for the fiscal year.

''(ii) SUBSECTION (b) STATE.—The term 'subsection (b) State' means one of the 50 States or the District of Columbia.'';

(3) in paragraph (2)(B), by striking ''the fiscal year'' and inserting ''the calendar year in which such fiscal year begins''; and

(4) in paragraph (3)(B), by striking ''the fiscal year involved'' and inserting ''the calendar year in which such fiscal year begins''.

(b) EFFECTIVE DATE.—The amendments made by this section apply to allotments determined under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) for fiscal year 2000 and each fiscal year thereafter.

SEC. 702. INCREASED ALLOTMENTS FOR TERRITORIES UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

Section 2104(c)(4)(B) (42 U.S.C. 1397dd(c)(4)(B)) is amended by inserting '', $34,200,000 for each of fiscal years 2000 and 2001, $25,200,000 for each of fiscal years 2002 through 2004, $32,400,000 for each of fiscal years 2005 and 2006, and $40,000,000 for fiscal year 2007'' before the period.

SEC. 703. IMPROVED DATA COLLECTION AND EVALUATIONS OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) FUNDING FOR RELIABLE ANNUAL STATE-BY-STATE ESTIMATES ON THE NUMBER OF CHILDREN WHO DO NOT HAVE HEALTH INSURANCE COVERAGE.—Section 2109 (42 U.S.C. 1397ii) is amended by adding at the end the following:

''(b) ADJUSTMENT TO CURRENT POPULATION SURVEY TO INCLUDE STATE-BY-STATE DATA RELATING TO CHILDREN WITHOUT HEALTH INSURANCE COVERAGE.—

''(1) IN GENERAL.—The Secretary of Commerce shall make appropriate adjustments to the annual Current Population Survey conducted by the Bureau of the Census in order to produce statistically reliable annual State data on the number of low-income children who do not have health insurance coverage, so that real changes in the uninsurance rates of children can reasonably be detected. The Current Population Survey should produce data under this subsection that categorizes such children by family income, age, and race or ethnicity. The adjustments made to produce such data shall include, where appropriate, expanding the sample size used in the State sampling units, expanding the number of sampling units in a State, and an appropriate verification element.

''(2) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2000 and each fiscal year thereafter for the purpose of carrying out this subsection.''.

(b) FEDERAL EVALUATION OF STATE CHILDREN'S HEALTH INSURANCE PROGRAMS.—Section 2108 (42 U.S.C. 1397hh) is amended by adding at the end the following:

''(c) FEDERAL EVALUATION.—

''(1) IN GENERAL.—The Secretary, directly or through contracts or interagency agreements, shall conduct an independent evaluation of 10 States with approved child health plans.

''(2) SELECTION OF STATES.—In selecting States for the evaluation conducted under this subsection, the Secretary shall choose 10 States that utilize diverse approaches to providing child health assistance, represent various geographic areas (including a mix of rural and urban areas), and contain a significant portion of uncovered children.

''(3) MATTERS INCLUDED.—In addition to the elements described in subsection (b)(1), the evaluation conducted under this subsection shall include each of the following:

''(A) Surveys of the target population (enrollees, disenrollees, and individuals eligible for but not enrolled in the program under this title).

''(B) Evaluation of effective and ineffective outreach and enrollment practices with respect to children (for both the program under this title and the medicaid program under title XIX), and identification of enrollment barriers and key elements of effective outreach and enrollment practices, including practices that have successfully enrolled hard-to-reach populations such as children who are eligible for medical assistance under title XIX but have not been enrolled previously in the medicaid program under that title.

''(C) Evaluation of the extent to which State medicaid eligibility practices and procedures under the medicaid program under title XIX are a barrier to the enrollment of children under that program, and the extent to which coordination (or lack of coordination) between that program and the program under this title affects the enrollment of children under both programs.

''(D) An assessment of the effect of cost-sharing on utilization, enrollment, and coverage retention.

''(E) Evaluation of disenrollment or other retention issues, such as switching to private coverage, failure to pay premiums, or barriers in the recertification process.

''(4) SUBMISSION TO CONGRESS.—Not later than December 31, 2001, the Secretary shall submit to Congress the results of the evaluation conducted under this subsection.

''(5) FUNDING.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2000 for the purpose of conducting the evaluation authorized under this

subsection. Amounts appropriated under this paragraph shall remain available for expenditure through fiscal year 2002.''.

(c) INSPECTOR GENERAL AUDIT AND GAO REPORT ON ENROLLEES ELIGIBLE FOR MEDICAID.—Section 2108 (42 U.S.C. 1397hh), as amended by subsection (b), is amended by adding at the end the following:

''(d) INSPECTOR GENERAL AUDIT AND GAO REPORT.—

''(1) AUDIT.—Beginning with fiscal year 2000, and every third fiscal year thereafter, the Secretary, through the Inspector General of the Department of Health and Human Services, shall audit a sample from among the States described in paragraph (2) in order to—

''(A) determine the number, if any, of enrollees under the plan under this title who are eligible for medical assistance under title XIX (other than as optional targeted low-income children under section 1902(a)(10)(A)(ii)(XIV)); and

''(B) assess the progress made in reducing the number of uncovered low-income children, including the progress made to achieve the strategic objectives and performance goals included in the State child health plan under section 2107(a).

''(2) STATE DESCRIBED.—A State described in this paragraph is a State with an approved State child health plan under this title that does not, as part of such plan, provide health benefits coverage under the State's medicaid program under title XIX.

''(3) MONITORING AND REPORT FROM GAO.—The Comptroller General of the United States shall monitor the audits conducted under this subsection and, not later than March 1 of each fiscal year after a fiscal year in which an audit is conducted under this subsection, shall submit a report to Congress on the results of the audit conducted during the prior fiscal year.''.

(d) COORDINATION OF DATA COLLECTION WITH DATA REQUIREMENTS UNDER THE MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT.—

(1) IN GENERAL.—Paragraphs (2)(D)(ii) and (3)(D)(ii)(II) of section 506(a) (42 U.S.C. 706(a)) are each amended by inserting ''or the State plan under title XXI'' after ''title XIX''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) apply to annual reports submitted under section 506 of the Social Security Act (42 U.S.C. 706) for years beginning after the date of the enactment of this Act.

(e) COORDINATION OF DATA SURVEYS AND REPORTS.—The Secretary of Health and Human Services, through the Assistant Secretary for Planning and Evaluation, shall establish a clearinghouse for the consolidation and coordination of all Federal databases and reports regarding children's health.

SEC. 704. REFERENCES TO SCHIP AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

The Secretary of Health and Human Services or any other Federal officer or employee, with respect to any reference to the program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) in any publication or other official communication, shall use—

(1) the term ''SCHIP'' instead of the term ''CHIP''; and

(2) the term ''State children's health insurance program'' instead of the term ''children's health insurance program''.

SEC. 705. SCHIP TECHNICAL CORRECTIONS.

(a) Section 2104(b)(3)(B) (42 U.S.C. 1397dd(b)(3)(B)) is amended by striking ''States.'' and inserting ''States,''.

(b) Section 2105(d)(2)(B)(iii) (42 U.S.C. 1397ee(d)(2)(B)(iii)) is amended by inserting ''in'' after ''described''.

(c) Section 2109(a) (42 U.S.C.1397ii(a)) is amended—

(1) in paragraph (1), by striking ''title II'' and inserting ''title I''; and

(2) in paragraph (2), by inserting '')'' before the period.

The Following is explanatory language on H.R. 3426, as introduced on November 17, 1999.

TITLE I—PROVISIONS RELATING TO PART A

SUBTITLE A-ADJUSTMENTS TO PPS PAYMENTS FOR SKILLED NURSING FACILITIES (SNFS)

SEC. 101. TEMPORARY INCREASE IN PAYMENT FOR CERTAIN HIGH COST PATIENTS

Current law

The SNF prospective payment system (PPS) includes 44 hierarchical resource utilization groups (RUGs). The RUGs are utilized to formulate the per diem payments to SNFs on behalf of Medicare patients. The RUG payments represent the average cost for patients in each RUG category. During a phase-in starting in 1998, the per diem payment is based partially on the facility's specific costs and partially on a federal per diem rate.

H.R. 3075, as passed

Increases temporarily the federal per diem payment by 10% for 12 RUGs in the ''Extensive Services,'' ''Special Care,'' and ''Clinically Complex'' categories. Increased payments would be made from April 1, 2000 through September 30, 2000.

S. 1788, as reported

Increases temporarily the federal per diem payment by 25% for ''Extensive Services'' and ''Special Care'' categories and adds specified dollar amounts to per diem rates for five RUGs for rehabilitation therapies. Increased payments would be made from April 1, 2000 through September 30, 2001.

Agreement

The agreement includes the Senate provision with amendments. For SNF services furnished on or after April 1, 2000, and before the later of October 1, 2000, or implementation by the Secretary of Health and Human Services (hereafter referred to as ''Secretary'') of a refined RUG system, per diem payments are increased by 20% for 15 RUGs falling under categories for Extensive Services, Special Care, Clinically Complex, High Rehabilitation, and Medium Rehabilitation. It is the intent of the parties to the agreement that the implementation begin on April 1, 2000, and that on this date, each payment shall increase by the required amount so that the facilities will receive payment authorized on April 1, 2000. In FY 2001 and 2002 the federal per diem payment to a facility is increased by 4% in each year, calculated exclusive of the 20% RUG rate increase.

SEC. 102. AUTHORIZING FACILITIES TO ELECT IMMEDIATE TRANSITION TO FEDERAL RATE

Current law

Payments to SNFs under the federal per diem RUG system are phased in over a period of time. Starting in 1998, a SNF receives per diem rates that are a blend of 75% of the facility-specific rate and 25% of the federal per diem rate. The proportions shift annually by 25 percentage points until the federal rate equals the full payment.

H.R. 3075, as passed

Permits SNFs to choose to receive payments based wholly on the federal per diem rate if that would be more advantageous to the facility; effective for elections made more than 60 days after enactment.

S. 1788, as reported

Permits SNFs to choose to receive payments based wholly on the federal per diem rate if that would be more advantageous to the facility; effective upon enactment.

Agreement

The agreement includes the House provision with modification. SNFs may elect immediate transition to the federal rate on or after December 15, 1999 for cost reporting periods beginning on or after January 1, 2000. There is no election for cost reporting periods beginning before January 1, 2000. SNFs may elect immediate transition up to 30 days after the start of their cost reporting period.

SEC. 103. PART A PASS-THROUGH PAYMENTS FOR CERTAIN AMBULANCE SERVICES, PROSTHESES, AND CHEMOTHERAPY DRUGS

Current law

SNF PPS payments are inclusive of ancillary services and drugs (except for renal dialysis services) needed by patients in specified RUGs.

H.R. 3075, as passed

Excludes certain items, starting April 1, 2000, from RUG payments. Provides separate payment for ambulance services for beneficiaries needing renal dialysis in a facility outside of the SNF, specific chemotherapy items and services, radioisotope services, and customized prosthetic devices delivered to the beneficiary during an inpatient SNF stay. Beginning with FY 2001, requires Secretary to reduce base RUG rates to account for exclusion of these items to ensure budget neutrality.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement include this provision in recognition that skilled nursing facilities (SNFs) from time to time experience high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment they receive under the prospective payment system (PPS). This provision is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs. For example, in the case of chemotherapy drugs, Health Care Financing Administration (HCFA) physicians excluded specific chemotherapy drugs from the PPS because these drugs are not typically administered in a SNF, or are exceptionally expensive, or are given as infusions, thus requiring special staff expertise to administer. Some chemotherapy drugs, which are relatively inexpensive and are administered routinely in SNFs, were excluded from this provision.

While this provision exempts ambulance services for end-stage renal disease (ESRD) patients, the parties to the agreement note that, in many cases, regularly scheduled trips may be made in vehicles that are less costly than an Advanced or Basic Life Support ambulance, and the parties to the agreement urge that SNFs use these cost-saving services appropriately.

The parties to the agreement recognize that excluding services or items from the PPS by specifying codes in legislation may not be the most appropriate way to protect SNFs from extraordinary events. Additionally, some items may have been inadvertently excluded from the list. New, extremely costly items may come into use or codes may change over time. Therefore, the parties to the agreement expect the Secretary to use her authority to review periodically and modify, as needed, the list of excluded services and items to reflect changes in codes and developments in medical technology. The parties to the agreement also request the General Accounting Office (GAO) to review the codes of the excluded items and make recommendations on whether the criteria for their exclusion are appropriate by July 1, 2000.

Section 1888(e)(5)(A) of the Social Security Act directed the Secretary to establish a SNF market basket index (MBI) that ''reflects the changes over time in the prices of

an appropriate mix'' of goods and services. The parties to the agreement believe that the Secretary should ensure that the current SNF MBI, as developed by the Secretary and based on Fiscal Year 1992 costs, fulfills this mandate. The parties to the agreement recognize that the Secretary revised and rebased the 1992 costs when developing the MBI; however, the Secretary should ensure that these types of modifications adequately reflect the costs of the efficient delivery of medically necessary new medications developed since 1992. Innovative medical research techniques, combined with significant technological advances, have led to the development of numerous new medications over the past seven years. The Secretary should ensure that these types of changes are represented in the current SNF MBI.

Accordingly, Congress expects the Secretary to: (1) evaluate the appropriateness of the SNF MBI with respect to medications used in the SNF population based on data from the first fiscal year after full implementation of the SNF PPS when they become available; (2) consider modification of the current SNF MBI as appropriate; and (3) ensure that the MBI continues to be responsive to new medications used by the SNF population.

SEC. 104. PROVISION FOR PART B ADD-ONS FOR FACILITIES PARTICIPATING IN THE NURSING HOME CASE MIX AND QUALITY (NHCMQ) DEMONSTRATION PROJECT

Current law

SNFs that had participated in the NHCMQ demonstration that preceded completion and implementation of the RUG/PPS do not have the cost of Part B services to their Medicare patients accounted for under the facility-specific component of the PPS during the transition period as do other SNFs.

H.R. 3075, as passed

Includes the cost of Part B services in the computation of the facility-specific component of the per diem payment during the transition to the federal per diem PPS for SNFs that had participated in the NHCMQ demonstration, including updates of the SNF market basket increase minus 1 percentage point, except for an increase in FY 2001 of the SNF market basket plus 0.8 percentage points. The provision becomes effective retroactively to implementation of the Balanced Budget Act of 1997 (BBA 97).

S. 1788, as reported

Similar to the House provision, with updates of the market basket increase minus 1 percentage point for cost reporting periods after 1997 and with allowances for exceptions payments.

Agreement

The agreement includes the House provision with a modification to keep the FY 2001 update at market basket minus 1 percentage point.

SEC. 105. SPECIAL CONSIDERATION FOR FACILITIES SERVING SPECIALIZED PATIENT POPULATIONS

Current law

No provision.

H.R. 3075, as passed

Provides temporarily for special per diem payments to be based 50% on the facility-specific rate and 50% on the federal rate for hospital-based SNFs: (1) that were certified for Medicare before July 1, 1992; (2) in 1998 served patients who were immuno-compromised secondary to an infectious disease; and (3) for which such patients accounted for more than 60% of the facility's total patient days in 1998. The special rates apply for the first cost reporting period starting after enactment and end on September 30, 2001. Requires the Secretary to assess and report within 1 year of enactment on the resource use of such patients and recommend whether permanent adjustments should be made to the RUGs in which they are classified.

S. 1788, as reported

Requires the Secretary to study and report to Congress within 1 year of enactment on alternative payment methods for SNFs specializing in caring for extremely high cost, chronically ill populations.

Agreement

The agreement includes the House provision.

SEC. 106. MEDPAC STUDY ON SPECIAL PAYMENT FOR FACILITIES LOCATED IN HAWAII AND ALASKA

Current law

No provision.

H.R. 3075, as passed

Requires the Medicare Payment Advisory Commission (MedPAC) to study and report within 18 months of enactment on the need for additional payments for SNFs in Alaska and Hawaii.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision.

SEC. 107. STUDY AND REPORT REGARDING STATE LICENSURE AND CERTIFICATION STANDARDS AND RESPIRATORY THERAPY COMPETENCY EXAMINATIONS

Current law

No provision.

H.R. 3075, as passed

No provision.

S. 1788, as reported

Requires the Secretary to report within 1 year of enactment on variations in state licensure and certification standards for workers providing respiratory therapy in SNFs and to make recommendations regarding Medicare requirements for licensing or certification.

Agreement

The agreement includes the Senate provision with modification.

SUBTITLE B—PPS HOSPITALS

SEC. 111. MODIFICATION IN TRANSITION FOR INDIRECT MEDICAL EDUCATION (IME) PERCENTAGE ADJUSTMENT

Current law

Medicare pays teaching hospitals for its share of the direct costs of providing graduate medical education, and the indirect costs associated with approved graduate medical education programs. Prior to BBA 97, Medicare's indirect medical education (IME) payments increased 7.7% for each 10% increase in a hospital's ratio of interns and residents to beds. BBA 97 reduced the IME adjustment to 6.5% in FY 1999; to 6.0% in FY 2000 and to 5.5% in FY 2001 and subsequent years.

H.R. 3075, as passed

Freezes the IME adjustment at 6.0% for FY 2001 and then reduces the adjustment to 5.5% in FY 2002 and subsequent years.

S. 1788, as reported

Freezes the IME adjustment at 6.5% through FY 2003 and then reduces the adjustment to 5.5% in FY 2004 and subsequent years.

Agreement

The agreement includes the Senate provision with modifications. The IME adjustment would be frozen at 6.5% through FY 2000. The adjustment would be reduced to 6.25% in FY 2001 and then to 5.5% in FY 2002 and subsequent years.

The parties to the agreement include in this provision a special adjustment to achieve the 6.5 percent IME payment for the first six months of FY 2000. Because the PPS rates for FY 2000 were set prior to enactment and claims have already been paid at the IME percentage adjustment of 6.0 percent as mandated in the Balanced Budget Act of 1997, reverting to the 6.5 percent IME percentage adjustment provided in this legislation would require re-processing of beneficiary claims. Due to necessary Year 2000 computer adjustments, the Secretary is unable to make payment changes until April 1, 2000, thus requiring a special adjustment to accommodate the changes made under this section. To prevent reprocessing of over 5 million beneficiary claims and reissuing an FY 2000 PPS payment rule, the payment difference between a 6.0 and a 6.5 IME percentage adjustment will be accomplished through an aggregate adjustment to teaching hospital payments.

SEC. 112. DECREASE IN REDUCTIONS FOR DISPROPORTIONATE SHARE HOSPITALS; DATA COLLECTION REQUIREMENTS

Current law

Medicare makes additional payments to hospitals that serve a disproportionate share of low-income Medicare and Medicaid patients. BBA 97 reduced the disproportionate share hospital (DSH) payment formula by 1% in FY 1998; 2% in FY 1999; 3% in FY 2000; 4% in FY 2001; 5% in FY 2002 and 0% in FY 2003 and in each subsequent year.

H.R. 3075, as passed

Freezes the reduction in the DSH payment formula to 3% in FY 2001. Changes the reduction to 4% in FY 2002.

Requires the Secretary to collect hospital cost data on uncompensated inpatient and outpatient care, including non-Medicare bad debt and charity care as well as Medicaid and indigent care charges. Requires the submission of the data in cost reports for cost reporting periods beginning on or after the enactment date.

S. 1788, as reported

Freezes the reduction in the DSH payment formula to 3% in FY 2001.

Agreement

The agreement includes the House provision with modification by requiring the Secretary to have hospitals submit the data requested in cost reports for cost reporting periods beginning on or after October 1, 2001.

This provision eases the financial burden of hospitals caring for a disproportionate share of low-income individuals. In addition, the Secretary is required to collect additional data necessary to develop a DSH payment methodology that takes into account the cost of serving uninsured and underinsured patients, as recommended by MedPAC. Presently, the DSH formula is based only on the costs associated with Medicaid patients and Medicare patients eligible for Supplementary Security Income (SSI). MedPAC has recommended that the formula be amended to include inpatient and outpatient costs associated with services provided to low-income patients, defined broadly to include all care to the poor.

In order to develop such a revised formula, it is necessary first to collect additional data. MedPAC recommends that data be collected on patients enrolled in state and local indigent care programs, as well as uncompensated care associated with uninsured or

underinsured patients. State and local indigent care programs would include non-federally financed programs with specific eligibility criteria for specified health care services. Financial data on state and local appropriations that offset uncompensated care expenses should also be collected. Uncompensated care costs and charges are those identified more typically as bad debt and charity care. While the parties to the agreement recognize that there may be problems in defining and appropriately measuring such costs and charges in a way that avoids duplication, such problems can best be overcome by developing standard definitions at the national level. The parties to the agreement expect the Secretary to report on the financial interactions and potential for shifts between Federal and State governments.

SUBTITLE C—PPS-EXEMPT HOSPITALS

SEC. 121. WAGE ADJUSTMENT OF PERCENTILE CAP FOR PPS-EXEMPT HOSPITALS

Current law

BBA 97 established a national cap on the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) limits for PPS-exempt hospitals at 75% of the target amount for that class of hospital.

H.R. 3075, as passed

Adjusts the labor-related portion of the 75% cap to reflect differences between the wage-related costs in the area of the hospital and the national average of such costs within the same class of hospitals beginning for cost reporting periods on or after October 1, 1999.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision.

SEC. 122. ENHANCED PAYMENTS FOR LONG-TERM CARE AND PSYCHIATRIC HOSPITALS UNTIL DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEMS (PPS) FOR THOSE HOSPITALS

Current law

BBA 97 established the amount of bonus and relief payments for eligible PPS-exempt providers.

H.R. 3075, as passed

Increases the amount of continuous bonus payments to the eligible long-term care and psychiatric providers from 1% to 1.5% for cost reporting periods beginning on or after October 1, 2000 and before September 30, 2001 and 2% for cost reporting periods beginning on or after October 1, 2001 and before September 30, 2002.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision.

SEC. 123. PER DISCHARGE PROSPECTIVE PAYMENT SYSTEM (PPS) FOR LONG-TERM CARE HOSPITALS

Current law

BBA 97 requires the Secretary to develop a legislative proposal for a PPS for long-term care hospitals that includes an adequate patient classification system by October 1, 1999.

H.R. 3075, as passed

Requires the Secretary to report to the appropriate Congressional committees by October 1, 2001 on a discharge-based PPS with an adequate patient classification system for long-term care hospitals which would be implemented in a budget-neutral fashion for cost reporting periods beginning on or after October 1, 2002. The Secretary may require such long-term care hospitals to submit information to develop the payment system.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision. In developing and evaluating the new PPS system, the parties to the agreement encourage the Secretary to measure the quality of outcomes.

SEC. 124. PER DIEM PROSPECTIVE PAYMENT SYSTEM (PPS) FOR PSYCHIATRIC HOSPITALS

Current law

No provision.

H.R. 3075, as passed

Requires the Secretary to report to the appropriate Congressional committees by October 1, 2001 on a per diem-based PPS with an adequate patient classification system for psychiatric hospitals and distinct-part units which would be implemented in a budget-neutral fashion for cost reporting periods beginning on or after October 1, 2002. The Secretary may require such psychiatric hospitals and units to submit information to develop the system.

S. 1788, as reported

Requires the Secretary to report to Congress within 2 years of enactment on a PPS for psychiatric hospitals and units. The study should take into account the unique circumstances of psychiatric hospitals in rural areas.

Agreement

The agreement includes the House provision. The parties to the agreement are aware that changes to payments for psychiatric units and hospitals contained in this bill could affect the provision of mental health services in rural areas. Accordingly, the parties to the agreement request that MedPAC evaluate the impact of these changes and make recommendations if further modifications are needed to maintain the availability of rural hospitals to provide critical behavioral health services.

SEC. 125. REFINEMENT OF PROSPECTIVE PAYMENT SYSTEM (PPS) FOR INPATIENT REHABILITATION HOSPITALS

Current law

BBA 97 requires the Secretary to establish a case-mix adjusted prospective payment system (PPS) for rehabilitation hospitals and distinct-part units, effective beginning in FY 2001. PPS rates are to be phased-in between October 1, 2000 and before October 1, 2002 with an increasing percentage of the hospitals' payment based on the PPS amount. For FY 2001 and FY 2002, the Secretary is required to establish prospective payment amounts so that total payments for rehabilitation hospitals equal 98% of the amount that would have been paid if the PPS had not been enacted. The inpatient rehabilitation hospital/distinct-part unit PPS will be fully implemented by October 1, 2002.

H.R. 3075, as passed

Changes the phase-in requirements to permit rehabilitation facilities to elect to have their payment based entirely on the PPS amount in FY 2001 and FY 2002. Changes the budget neutrality requirement for FY 2001 and FY 2002 to account for the facilities that have elected to be fully reimbursed on the PPS amount during the transition period. Requires the Secretary, after obtaining substantially complete FY 2001 data, to analyze the extent to which changes in case-mix (or changes in the severity of illnesses) are attributable to changes in medical record coding and patient classification and do not reflect real changes in case-mix. Based on the analysis of the case-mix change attributable to coding and classification change, the Secretary shall adjust FY 2004 PPS rates by 150% of the estimate of the PPS percentage adjustment that would have achieved budget neutrality in FY 2001 if it had applied to setting the rates for that fiscal year. If this FY 2004 adjustment resulted in a percentage decrease in the rates, the Secretary shall increase the FY 2005 PPS rates by a percentage equal to ⅓ of such percentage decrease. If this FY 2004 adjustment resulted in a percentage increase in the rates, the Secretary shall decrease the FY 2005 PPS rates by a percentage equal to 1/3 of such percentage increase.

Requires the Secretary to base PPS on discharges. Requires the Secretary to establish classes of patient discharges of rehabilitation facilities by functional-related groups, based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of Functional Independence Measure-Function Related Groups (FIMFRGs). Clarifies that the Secretary may adjust payments to account for the early transfer of a patient from a rehabilitation facility to another site of care. Requires the Secretary to submit a study to Congress not later than 3 years after the implementation of the PPS of its impact on utilization and access.

S. 1788, as reported

Bases the PPS on discharges classified according to functional-related groups based on impairment, age, comorbidities, and functional capability of the patient as well as other factors deemed appropriate to improve the explanatory power of FIMFRGs. Requires the Secretary to submit a study to Congress, not later than 2 years after implementation of PPS, of its impact on service utilization, beneficiary access, non-therapy ancillary services and other factors that the Secretary determines to be appropriate. The study should include legislative recommendations on payment adjustments as appropriate.

Agreement

The agreement includes the House provision with amendments.

SUBTITLE D—HOSPICE CARE

SEC. 131. TEMPORARY INCREASE IN PAYMENT FOR HOSPICE CARE

Current law

Hospice payments are based on one of four prospectively determined daily rates which correspond to levels of care. Before BBA 97, the rates were updated annually by the hospital market basket; BBA 97 reduced the updates to market basket minus 1 percentage point for FY 1999 through FY 2002 and required the Secretary to collect hospice cost data.

H.R. 3075, as passed

No provision.

S. 1788, as reported

Changes the hospice update to market basket minus 0.5 percentage point through FY 2002.

Agreement

The agreement includes the Senate provision with an amendment. For each of fiscal years 2001 and 2002, hospice payment rates (otherwise in effect for those years) are increased by 0.5 percent and 0.75 percent, respectively. The Secretary is prohibited from including these additional payments in the updates of payment rates after FY 2002.

SEC. 132. STUDY AND REPORT TO CONGRESS REGARDING MODIFICATION OF THE PAYMENT RATES FOR HOSPICE CARE

Current law

The Secretary is required to collect data from hospices on the costs of care provided for each fiscal year beginning with FY 1999.

H.R. 3075, as passed

No provision.

S. 1788, as reported

Requires the GAO to conduct a study on the feasibility and advisability of updating the hospice rates and certain capped payment amounts, including an evaluation of whether the cost factors used to determine the rates should be modified, eliminated, or supplemented with additional cost factors. The report and recommendation are to be submitted to Congress within 1 year of enactment.

Agreement

The agreement includes the Senate provision.

SUBTITLE E—OTHER PROVISIONS

SEC. 141. MEDPAC STUDY ON MEDICARE PAYMENT FOR NON-PHYSICIAN HEALTH PROFESSIONAL CLINICAL TRAINING IN HOSPITALS

Current law

BBA 97 required that, not later than 2 years after enactment, MedPAC submit to Congress a study of Medicare's graduate medical education payment policy and reimbursement methodologies including whether and to what extent payments are being made (or should be made) for training in nursing and other allied health professions.

H.R. 3075, as passed

Requires MedPAC, within 18 months of enactment, to submit to Congress a study of Medicare payment policy with respect to professional clinical training of different types of non-physician health care professionals (such as nurses, nurse practitioners, allied health professionals, physician assistants, and psychologists).

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement recognize that MedPAC has considered non-physician clinical training in its report to the Congress on long-term policies for graduate medical education. However, the parties to the agreement require additional explicit information on Medicare's role in financing clinical training for non-physician health professionals. A continuation of the existing effort, combined with quantitative analysis, will provide the Congress with all aspects of Medicare's support for health professional training, including possible methodologies for making payments and the entities that should receive them.

The parties to the agreement are pleased that the Secretary, consistent with language included in the Conference Report (Report 105–217) of the Balanced Budget Act of 1997, is considering a proposal to initiate graduate medical education payments to institutions involved in the training of clinical psychologists. The parties to the agreement urge the Secretary to issue a notice of proposed rulemaking to accomplish this modification before June 1, 2000.

SUBTITLE F—TRANSITIONAL PROVISIONS

SEC. 151. EXCEPTION TO CMI QUALIFIER FOR ONE YEAR

Current law

The Secretary is authorized to allow for exceptions and adjustments to the amount paid under PPS for hospitals that act as regional or national referral centers for patients transferred from other hospitals. Generally, a referral center is located in a rural area, has at least 275 or more beds, can show that at least 50% of its Medicare patients are referred from other hospitals, and that at least 60% of its Medicare patients live more than 25 miles from the hospital or that 60% of all the services that the hospital furnishes to Medicare beneficiaries are furnished to those that live more than 25 miles from the hospital.

Alternatively, a hospital may meet certain other specified criteria including (1) a case-mix index above the national average or above the median case-mix value for urban hospitals located in that region; (2) a number of discharges greater than 5,000 or, if less, above the median number of discharges for urban hospitals in the region; (3) more than 50% of the hospital's active medical staff are specialists; (4) at least 60% of all its discharges are for patients who live more than 25 miles from the hospital; or (5) at least 40% of all patients treated at the hospital are referred from other hospitals or by physicians not on the hospital's staff. These referral centers receive preferential treatment in the Medicare inpatient PPS for the disproportionate share hospital payment adjustment and when considered for geographic reclassification.

H.R. 3075, as passed

No provision.

S. 1788, as reported

Deems that Northwest Mississippi Regional Medical Center meets the case-mix index criterion for classification as a referral center for FY 2000.

Agreement

The agreement includes the Senate provision.

SEC. 152. RECLASSIFICATION OF CERTAIN COUNTIES AND AREAS FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM

Current law

Medicare's inpatient hospital PPS payments vary by urban/rural classification and the geographic area where a hospital is located or to which a hospital is assigned.

H.R. 3075, as passed

No provision.

S. 1788, as reported

Deems that: Iredell County, NC is to be considered part of the Charlotte-Gastonia Rock Hill NC-SC Metropolitan Statistical Area (MSA); and Orange County, NY is to be considered part of the large urban area of New York, NY for discharges occurring on or after October 1, 1999.

Agreement

The agreement contains the Senate provision with modifications. For purposes of Medicare reimbursement, Lake County, Indiana and Lee County, Illinois are deemed to be considered part of the Chicago, Illinois MSA; Hamilton-Middletown, Ohio is deemed to be considered part of the Cincinnati, Ohio-Kentucky-Indiana MSA; Brazoria County, Texas is deemed to be considered part of the Houston, Texas MSA; and Chittenden County, Vermont is deemed to be considered part of the Boston-Worcester-Lawrence-Lowell-Brockton, Massachusetts-New Hampshire MSA. These counties would be reclassified for the purposes of the Medicare inpatient PPS in FY 2000 and FY 2001.

SEC. 153. WAGE INDEX CORRECTION

Current law

Medicare's inpatient hospital PPS payments are adjusted to reflect the wage level in the geographic area where a hospital is located or to which a hospital is assigned. Hospitals can only submit and correct wage data during specified times. All payment changes that result from changes to the wage data are implemented in a budget-neutral fashion.

H.R. 3075, as passed

No provision.

S. 1788, as reported

Requires the Secretary to recalculate and apply the Hattiesburg, MS MSA wage index for FY 2000 using FY 1996 wage and hour data for Wesley Medical Center. The Secretary is instructed to adjust PPS to take into account the corrected wage index.

Agreement

The agreement includes the Senate provision with modifications. The wage index recalculation would not affect the wage indices for any other areas.

SEC. 154. CALCULATION AND APPLICATION OF WAGE INDEX FLOOR FOR A CERTAIN AREA

Current law

Medicare's inpatient hospital PPS payments are adjusted to reflect the wage level in the geographic area where a hospital is located or to which a hospital is assigned. Hospitals can only submit and correct wage data during specified times. All payment changes that result from changes to the wage data are implemented in a budget-neutral fashion.

H.R. 3075, as passed

No provision.

S. 1788, as reported

No provision.

Agreement

The agreement would require the Secretary to calculate and apply the wage index for the Allentown-Bethlehem-Easton MSA for FY 2000 as if Lehigh Valley Hospital were classified in such area. Such recalculation would not affect the wage index for any other area. For FY 2001, Lehigh Valley Hospital would be treated as being classified to the Allentown-Bethlehem-Easton MSA.

SEC. 155. SPECIAL RULE FOR CERTAIN SKILLED NURSING FACILITIES

Current law

The SNF prospective payment system pays SNFs a per diem amount for all covered services provided to Medicare beneficiaries. During a transition period lasting through the three cost reporting periods beginning on or after July 1, 1998, a portion of the per diem payment to a SNF will be based on a facility-specific rate, and the remaining portion on a federal rate. By the end of the transition, 100% of the per diem payment will be based on the federal rate. Federal and facility-specific payments are based on updated 1995 cost reports.

H.R. 3075, as passed

No provision.

S. 1788, as reported

No provision.

Agreement

The agreement includes provisions to require the Secretary to establish for each cost reporting period beginning in FY 2000 and in FY 2001, special per diem payments for SNFs: (1) that began participation in the Medicare program before January 1, 1995; (2) for which at least 80 percent of total inpatient days of the facility in the cost reporting beginning in 1998 were comprised of persons entitled to Medicare; and (3) that are located in Baldwin or Mobile County, Alabama. The payment amount would be equal to 100 percent of the facility-specific rate, which would be based on allowable costs for the cost reporting period beginning in FY 1998.

TITLE II—PROVISIONS RELATING TO PART B

SEC. 201. OUTLIER ADJUSTMENT; TRANSITIONAL PASS-THROUGH FOR CERTAIN MEDICAL DEVICES, DRUGS, BIOLOGICALS

Current law

Under the hospital outpatient PPS, payments will be uniform for all patients undergoing a certain procedure in certain hospitals. Currently, beneficiaries pay 20% of charges for outpatient services. Under the outpatient PPS, beneficiary copayments will

be limited to frozen dollar amounts based on 20% of the national median of charges for services in 1996, updated to the year of implementation of the PPS.

H.R. 3075, as passed

For certain high cost (or ''outlier'') patients, permits the Secretary to determine and provide additional payments to hospitals for each covered service for which the hospital's costs exceed a fixed multiple of the PPS amount, including any ''transitional pass-through'' payments and including other adjustments. The pool of funds for such outlier payments may not exceed 2.5% of total program costs in years before 2004 and 3.0% thereafter, but must be budget-neutral.

Allows for 2 to 3 years of payments to be made in addition to PPS payments (''transitional pass through'' payments) for innovative medical devices, drugs, and biologicals, including orphan drugs, cancer therapy drugs and biologicals, and certain ''new'' medical devices, drugs, and biologicals. The pool of funds for such items would be 2.5% for years up to 2004 and 2% thereafter, but must be budget-neutral.

For the outpatient PPS, defines covered outpatient services to include implantable medical devices; gives the Secretary the option of basing the system's relative payment weights on the mean or the median of hospital costs.

Limits cost range of services and items (except for orphan drugs) comprising a cost group on which a prospective payment is based. Provides that beneficiary copayments will not reflect Medicare payments to hospitals for outlier costs or transitional pass through payments for certain drugs, biologicals, and devices.

S. 1788, as reported

Similar to House provision with additional transitional pass-through payments for radiopharmaceuticals.

Agreement

The agreement includes the House provision with amendments: the agreement includes a transitional pass-through of costs of radiopharmaceuticals. In addition, the agreement allows the Secretary to apply outlier payments for covered outpatient services furnished before January 1, 2002, for individual outpatient encounters, using an appropriate cost-to-charge ratio for the hospital rather than for the specific departments within the hospital.

It is the intent of the conferees that the phase-down in beneficiary coinsurance for hospital outpatient services enacted by the Balanced Budget Act of 1997 not be delayed further by any changes to the hospital outpatient prospective payment system included in this bill. The BBA 97 provision was intended to fix an anomaly in the law that resulted in Medicare beneficiaries paying more than 20 percent in coinsurance for hospital outpatient services. There has already been a one-year delay in the implementation of the BBA 97 provision. The conferees fully expect that the beneficiary coinsurance phase-down will commence, as scheduled, on July 1, 2000, and that beneficiary coinsurance for outpatient department (OPD) services will be frozen until it equals 20 percent of the Medicare OPD fee schedule amount, which should be determined without regard to any outlier adjustments, adjustments that limit payment declines, or transitional add-on payments.

The parties to the agreement believe that HCFA's plans for implementing the outpatient prospective payment system (PPS), as described in HCFA's September 7, 1998 proposed regulation, raise many concerns. The proposal: (1) fails to provide adjustments for high cost care; (2) does not adequately provide a transition to include medical devices, drugs and biologicals in the system, and; (3) will not be updated annually to keep pace with changes in technology and medical practice. The Committee is making several structural changes to improve the design of the outpatient PPS and to assure that patients are not denied access to needed care.

In the proposed regulation, HCFA classified many different services with varying costs into a single payment group. In one example, brachytherapy has been placed in a group with other procedures that are much less costly. This could provide disincentives to use this technology. The Committee believes that while some level of variation is unavoidable, there should not be wide variation that could potentially restrict access to the most costly services. To address this problem, this agreement would place an upper limit on the variation of costs among services included in the same group. The most costly item or service in a group could not have a mean or median cost that was more than twice the mean or median cost of the least costly item or service in the group. To provide additional flexibility, the parties to the agreement give the Secretary the option to base the relative payment weights on either the mean or median cost of the items and services in a group. Further, in classifying drugs and biologicals into payment categories, the parties to the agreement expect that consideration will be given to products that are therapeutically equivalent.

The parties to the agreement recognize that there may be unusual cases, such as low volume items and services, and the Secretary is given discretion to exempt these exceptional cases from the limitation. The parties expect that the Secretary would not use this exception to include orphan drugs in a group that contains very different resources.

In the proposed regulation, HCFA stated its intention not to update the payment groups and rates annually. This is different from the agency's process of annually updating the inpatient prospective payment system. Given the rapid pace of technological change as well as changes in medical practice, the parties to the agreement require the Secretary to review the outpatient payment groups and amounts annually and to update them as necessary.

BBA 97 gave the Secretary the discretion to make additional payments (called outlier payments) to hospitals for particularly costly cases. The parties to the agreement require the Secretary to make outlier payments in a budget neutral manner and in a similar way as is currently done in the inpatient PPS. The outlier pool would be established at any level up to 2.5 percent of total payments for the first three years under the new system. After the third year, the pool could be set at any level up to 3 percent of total payments.

While the statutory provisions for the inpatient PPS require an outlier pool equal to a level between 5 and 6 percent of total inpatient PPS payments, the Committee believes that the lower levels of 2.5 and 3.0 percent are more appropriate for the outpatient PPS because the outpatient PPS will make separate payments for most individual services performed during an outpatient encounter. The allowed upper limit on the size of the pool is increased after the third year because the need for outlier payments may increase after the temporary add-on payments for drugs and biologicals, described below, are replaced with a transitional provision that applies only to new products.

The parties to the agreement are concerned that HCFA's proposed payment system does not adequately address issues pertaining to the treatment of drugs, biologicals and new technology. The parties believe that these oversights could lead to restricted beneficiary access to drugs, biologicals and new technology. The provisions would establish transitional payments to cover the added costs of certain services involving the use of medical devices, drugs and biologicals. Hospitals using these drugs, biologicals and devices would be eligible for additional payments.

The duration of the transitional payment would be for a period of at least two years but not more than three years. For drugs, biologicals, and brachytherapy used in cancer therapy and orphan drugs, the period would begin with the implementation date of the outpatient PPS. This also would be the period applicable to medical devices first paid as an outpatient hospital service after 1996 but before implementation of the outpatient PPS (as well as for any other item or service eligible for the additional payments at the inception of the outpatient PPS because of insufficient data or use of the Secretary's discretion). For products first paid as an outpatient service after implementation of the outpatient PPS, the transitional payment would begin with the first date on which payment is made for the device, drug or biological as an outpatient hospital service and continue for at least two, but not more than three, years.

The parties to the agreement expect the Secretary to develop a process to address new devices, drugs and biologicals introduced after the outpatient fee schedule for a particular year has been set. This process should include assigning an appropriate code (or codes) to the product and establishing the amount of the add-on payment. New codes and add-on payment amounts should be made effective quarterly.

The amount of the additional payment to hospitals, before applying the limitation described below, should equal the amount specified for the new technology less the average cost included in the outpatient payment schedule for the existing technology. Specifically, for drugs and biologicals, the amount of the additional payment is the amount by which 95 percent of the Average Wholesale Price (AWP) exceeds the portion of the applicable outpatient fee schedule amount that the Secretary determines is associated with the drug or biological. Similarly, for new medical devices, the add-on payment is the amount by which the hospital's charges for the device, adjusted to cost, exceed the outpatient fee schedule amount associated with the device.

The total amount of additional pass-through payments in a year should not exceed a prescribed percentage of total projected payments under the outpatient prospective payment system. The applicable percentages are: (1) 2.5 percent for the first three years after implementation of the new outpatient payment system; and (2) up to 2.0 percent in subsequent years. In setting the hospital outpatient department (OPD) rates and add-on amounts for a particular year, the Secretary will estimate the total amount of additional payments that would be made based on the add-on amounts specified above and the expected utilization for each service. If the estimated total amount exceeds the percentage limitation, the Secretary will apply a pro rata reduction to the add-on payment amounts so that projected total payments are within the limitation.

The parties to the agreement believe that the current DMEPOS fee schedule is not appropriate for certain implantable items, since their use in the hospital setting involves the provision of services by the hospital. It is the parties' intent that payment for implantable medical items (for example,

pacemakers, defibrillators, cardiac sensors, venous grafts, drug pumps, stents, neurostimulators, and orthopedic implants), as well as for items that come into contact with internal human tissue during invasive medical procedures (but are not permanently implanted), will be made through the outpatient PPS system—regardless of how these products might be classified on current HCFA fee schedules.

The parties to the agreement understand that the Secretary is committed to creating separate payment categories for blood, blood products, and plasma-based and recombinant therapies. The parties to the agreement continue to be concerned that the inadequate payment for these products and therapies could represent a barrier to patient access. Accordingly, the parties to the agreement expect the Secretary to carefully analyze potential patient access issues and create sufficient payment categories to adequately differentiate these products.

The agreement also requires the Secretary to conduct a study of intravenous immune globulin (IVIG) services in settings other than hospital outpatient departments and physicians' offices to be completed within 1 year of enactment. In addition, the agreement requires the Secretary to make recommendations on the appropriate manner and settings under which Medicare should pay for these services in such settings.

The parties to the agreement encourage the Secretary to examine Medicare policies regarding outpatient rehabilitation services (including cardiac and pulmonary rehabilitation services) in hospital outpatient departments and other ambulatory settings in light of advances in medical technology.

SEC. 202. ESTABLISHING A TRANSITIONAL CORRIDOR FOR APPLICATION OF OPD PPS

Current law

The hospital outpatient PPS is to be implemented in full and simultaneously for all services and hospitals (estimated for July 2000).

H.R. 3075, as passed

Provides payments in addition to PPS payments to a hospital during the first 3 years of the PPS if its PPS payments are less than the payments that would have been made prior to the PPS. During the first year, a hospital would receive an additional amount equal to 80% of the first 10% of the difference between its payments under the prior system and under the PPS, 70% of the next 10% of reduced payments, and 60% of the next 10%. If PPS payments are less than 70% of prior levels, the additional sum is 21% of the pre-BBA amount. During the second year, the payments as a proportion of reduced payments would change to 70% of the first 10% and 60% of the second 10%. If PPS payments are less than 80% of prior amounts the additional sum is 13% of the pre-BBA amount. In the third year, the payment would be 60% of the first 10% of reduced payments, and if the PPS payments are less than 90% of the prior amounts, the additional payment is 6% of the pre-BBA amount. These additional payments would be made through 2003.

Until January 1, 2004, for rural hospitals with fewer than 100 beds, provides special payments to bring payments to hospital outpatient departments up to their pre-PPS amounts if their PPS payments are less than under the prior system. Waives budget neutrality for these payments; applies BBA 97 beneficiary copayment rules. Requires the Secretary to report by July 1, 2002, on whether the outpatient PPS should apply to Medicare dependent small rural hospitals; sole community hospitals; rural health clinics; rural referral centers; rural hospitals with 100 or fewer beds; other rural hospitals as determined by the Secretary.

S. 1788, as reported

Requires the Secretary to increase payments under the hospital outpatient PPS in amounts such that the ratio of Medicare payments (after correction for the formula-driven overpayment) plus beneficiary copayments to hospital costs would be no less than 90%, 85%, and 80% of the ratio of the hospital's 1996 payments-to-costs in the first, second, and third years of the new system, respectively. Authorizes the Secretary to make interim payments to hospitals during these 3 years and to make subsequent retroactive adjustments. The budget neutrality requirement of the PPS is waived. For each year beginning in 2000, the Secretary is authorized to increase permanently PPS payments to Medicare dependent small rural hospitals, sole community hospitals, and cancer hospitals to amounts such that the ratio of Medicare payments plus beneficiary copayments to a hospital's costs would be not less than that ratio in 1996. Beneficiary copayment reductions in BBA 97 would be protected for care in these facilities. The BBA 97 budget neutrality requirements would be waived for these payments.

Agreement

The agreement includes the House and Senate provisions with amendments. The agreement includes the House corridor amounts and a temporary hold harmless provision for small rural hospitals with modifications. It also includes the Senate's permanent hold harmless provision for cancer hospitals under the PPS. For services furnished before January 1, 2004, by rural hospitals with not more than 100 beds, Medicare payments will equal 100% of the hospitals' pre-BBA outpatient payment amounts if their PPS amount is less than the pre-BBA amount. On a permanent basis, Medicare payments to cancer hospitals will equal 100% of their pre-BBA amount if their PPS amount is less than their pre-BBA amount. Pre-BBA amount is defined as the amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital's cost reporting period (or periods) occurring in the year and the base OPD payment-to-cost ratio for the hospital, excluding formula-driven overpayments.

SEC. 203. STUDY AND REPORT TO CONGRESS REGARDING THE SPECIAL TREATMENT OF RURAL AND CANCER HOSPITALS IN PROSPECTIVE PAYMENT SYSTEM (PPS) FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Current law

No provision.

H.R. 3075, as passed

Requires the Secretary to submit a report and recommendations to Congress by July 1, 2002 on whether a hospital outpatient prospective payment system (PPS) should continue to apply to Medicare Dependent Hospitals, Sole Community Hospitals, rural health clinics, rural referral centers, and other rural hospitals.

S. 1788, as reported

Requires MedPAC to prepare a report to the Secretary of HHS and the Congress within 2 years of enactment regarding the feasibility and advisability of including cancer hospitals and rural hospitals in the outpatient PPS. After submission of the report, the Secretary shall submit comments on the report within 60 days.

Agreement

The agreement includes the Senate provision with modifications.

SEC 204. LIMITATION ON OUTPATIENT HOSPITAL COPAYMENT FOR A PROCEDURE TO THE HOSPITAL DEDUCTIBLE AMOUNT

Current law

When the hospital outpatient PPS is implemented, BBA 97 freezes beneficiary copayments at the dollar amount that is equal to 20% of national median changes for a procedure in 1996 updated to 1999 (or the year of implementation of the PPS).

H.R. 3075, as passed

Caps beneficiary copayments under the PPS for care and services in hospital outpatient departments to the dollar amount of the deductible for an inpatient hospital stay under Part A. Provides Medicare payments to make up the difference between the frozen copayment amount and the new limit. Effective retroactively to enactment of the BBA 97.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision.

Subtitle B—Physician Services

SEC. 211. MODIFICATION OF UPDATE ADJUSTMENT FACTOR PROVISIONS TO REDUCE UPDATE OSCILLATIONS AND REQUIRE ESTIMATE REVISIONS

Current law

Payments to physicians are made on the basis of a fee schedule which assigns a relative value unit to each service. The conversion factor is a dollar figure that converts the geographically adjusted relative value into a dollar payment amount. This amount is updated each year. Beginning in 1999, the update percentage equals the Medicare Economic Index (MEI), subject to an adjustment to match actual spending to target spending for physicians services under the sustainable growth rate (SGR) system.

H.R. 3075, as passed

Makes technical changes to limit oscillations in the annual update to the conversion factor beginning in 2001 by: (a) requiring that future update adjustment factors be calculated using data measured on a calendar year basis; (b) modifying the formula for determining the update by adding a new component to the formula to measure past year variances from allowed spending growth; and (c) mitigating the year-to-year impact of these measures on the update by the addition of dampening multipliers. Provides for a budget-neutral transition to the revised system. Provides that the SGR is to be calculated on a calendar basis. Requires that an estimate of the conversion factor and SGR be made available to MedPAC and the public by March 1 of each year, MedPAC comments in its annual report, and final publication November 1. Requires the Secretary to use the best available data to revise prior SGR estimates for up to 2 years after the estimate is first published. Provides that provision would not apply to or affect any update for any year before 2001.

S. 1788, as reported

Nearly identical provision. In addition, requires the Secretary, acting through the Administrator of the Agency for Health Care Policy and Research, to conduct a study on the utilization of physicians services under the fee-for-service program.

Agreement

The agreement includes the House provision with Senate amendment to include the AHCPR study. With regard to physician supervision of anesthesia services under Medicare's Conditions of Participation, if the

Secretary determines that there is insufficient current scientific data comparing mortality and adverse outcome rates in the provision of anesthesia services to Medicare patients, the Secretary should conduct a comparative outcome study and report back to the parties to the agreement. If the Secretary believes that she has sufficient mortality and quality information regarding the provision of anesthesia services by nurse anesthetists and anesthesiologists, then she could make the appropriate regulatory changes to ensure access to quality care for Medicare beneficiaries.

SEC. 212. USE OF DATA COLLECTED BY ORGANIZATIONS AND ENTITIES IN DETERMINING PRACTICE EXPENSE RELATIVE VALUES

Current law

The Social Security Act Amendments of 1994 (P.L. 103–432) required the Secretary to develop a methodology for a resource-based system for calculating practice expenses which would be implemented in calendar year 1998. BBA 97 delayed implementation of a resource-based practice expense methodology for a year, until 1999. BBA 97 also reduced certain practice expense relative value units in 1998. The new resource-based system is being phased-in beginning in calendar year 1999; 1998 is used as the base year for the calculation. Beginning in 2002, the values will be totally resource-based.

H.R. 3075, as passed

Requires the Secretary to establish by regulation a process (including data collection standards) under which the Secretary would accept for use and would use, to the maximum extent practicable and consistent with sound data practices, data collected by organizations and entities other than HHS. Requires a report to the Secretary on the process and the extent to which such data has been used.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement direct the Secretary to give fair consideration to data submitted by external entities. The parties to the agreement are particularly concerned about the instances when HCFA may not have adequate data for rate setting.

SEC. 213. GAO STUDY ON RESOURCES REQUIRED TO PROVIDE SAFE AND EFFECTIVE OUTPATIENT CANCER THERAPY

Current law

No provision.

H.R. 3075, as passed

Requires a study and report to Congress on resources required to provide safe and effective outpatient cancer therapy and the appropriate payment rates for such services.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement direct the Comptroller General to determine the adequacy of practice expenses associated with the utilization of outpatient cancer clinical resources, examine the current level of work values in the practice expense formula, and assess various standards to assure the provision of safe outpatient cancer therapy services. The parties to the agreement also direct the Comptroller General to submit to Congress a report on this study. As part of the study, the Comptroller General is directed to make recommendations regarding adjustments to practice expense values in effect under Part B of the Medicare program and the impact on program costs. In addition, the parties to the agreement encourage the Comptroller General to examine the variation in Medicare payments for these services in hospital and non-hospital settings.

SUBTITLE C—OTHER SERVICES

SEC. 221. REVISION OF PROVISIONS RELATING TO THERAPY SERVICES

Current law

BBA 97 set annual payment limits for all outpatient therapy services provided by non-hospital providers. There are two per beneficiary limits. The first is a $1,500 per beneficiary annual cap for all outpatient physical therapy services and speech language pathology services. The second is a $1,500 per beneficiary annual cap for all outpatient occupational therapy services. The Secretary is required to report to Congress by Jan. 1, 2001 on recommendations for establishing a revised payment policy based on diagnostic groups.

H.R. 3075, as passed

Creates separate $1,500 caps for physical therapy and speech-language pathology services which would be applied to services furnished on a per beneficiary, per facility (or provider) basis beginning in 2000. The cap on occupational therapy services would also be applied on a per beneficiary, per facility (or provider) basis. Directs the Secretary to establish a process so that a facility or provider may apply for an increase in the limitation for a beneficiary for services furnished in 2000 or 2001; limits additional payments to $40 million in FY2000, $60 million in FY2001, and $20 million in FY2002.

In addition, H.R. 3075 specifies that an optometrist may meet the physician supervision requirement for outpatient physical therapy services. Current law limits outpatient occupational therapy services to services furnished to individuals who are under the care of a medical doctor, doctor of osteopathy, or podiatrist. Persons suffering from low vision (visual impairments not correctable using conventional eyewear) may be under the care of either a medical doctor, doctor of osteopathy, or optometrist. The provision would clarify that rehabilitation services for these individuals may be covered when the patient is under the care of, and the treatment plan has been ordered by, either a medical doctor, doctor of osteopathy, or optometrist.

S. 1788, as reported

Provides that the cap would not apply in 2000 and 2001. Modifies current report to Congress to include recommendation for assuring appropriate utilization and incorporation of functional status in recommended payment modifications. Requires Secretary to study utilization patterns in 2000 compared to those in 1998 and 1999.

Agreement

The agreement includes the Senate provision with a modification requiring the Secretary to conduct focused medical reviews of therapy services during 2000 and 2001, with emphasis on claims for services provided to residents of SNFs.

The agreement also includes the House provision regarding optometrists and the supervision of outpatient physical therapy services. The parties to the agreement note that the extent to which these rehabilitation services are covered is a coverage decision made by carriers and the Health Care Financing Administration. Based on an agreement between organizations representing ophthalmology and optometry on appropriate low vision rehabilitation services, the parties to the agreement expect that referral for low vision rehabilitation services by optometrists would be limited to three codes—97530, 97535, and 97537.

SEC. 222. UPDATE IN RENAL DIALYSIS COMPOSITE RATE

Current law

Dialysis facilities providing care to beneficiaries with end-stage renal disease (ESRD) receive a fixed prospective payment amount for each dialysis treatment. The base composite rate is $126 for hospital-based providers and $122 for free-standing facilities.

H.R. 3075, as passed

Updates the composite rate by 1.2% for dialysis services furnished during CY2000 and an additional 1.2% for services furnished in CY2001. Requires a MedPAC study on the use of home dialysis services by Medicare beneficiaries.

S. 1788, as reported

Updates the rate for services furnished after October 1, 2000 by 2.0%.

Agreement

The agreement includes the House provision.

SEC. 223. IMPLEMENTATION OF THE INHERENT REASONABLENESS (IR) AUTHORITY

Current law

The Secretary has the authority to modify payment rates for Part B services (other than physicians services) if such rates (as determined by prevailing payment methodologies) are ''grossly excessive or grossly deficient'' and therefore inherently unreasonable. The Secretary is required, by regulation, to describe the factors to be used in making inherent reasonableness determinations. Interim final regulations describing such factors were issued January 7, 1998.

H.R. 3075, as passed

Prohibits the Secretary from exercising inherent reasonableness authority until after the Secretary has issued final rule-making. Specifies that final rule-making must be preceded by new proposed rule-making and a minimum 60-day public comment period.

S. 1788, as reported

Prohibits the Secretary from using inherent reasonableness authority until 90 days after the GAO issues a report regarding this issue.

Agreement

The agreement includes the House and Senate provisions with modifications to prohibit the Secretary from using inherent reasonableness authority until after (1) the GAO releases a report regarding the Secretary's recent use of the authority; and (2) the Secretary has published a notice of final rule-making in the Federal Register that responds to the GAO report and to comments received in response to the Secretary's interim final regulation published January 7, 1998. In promulgating the final regulation, the Secretary is required to (1) reevaluate the appropriateness of the criteria included in the interim regulation for identifying payments which are excessive or deficient; and (2) take appropriate steps to ensure the use of valid and reliable data when exercising the authority. The parties to the agreement believe that the inherent reasonableness authority provided by section 1842(b) should be administered judiciously and applied only after public concerns and suggestions about proposed administrative criteria have been openly addressed. Also, the rules should include an explanation of the Secretary's costing methodology which should be based on statistically reliable and relevant data.

SEC. 224. INCREASE REIMBURSEMENT FOR PAP SMEARS

Current law

Medicare pays for Pap smears under the clinical laboratory fee schedule.

H.R. 3075, as passed

Sets the minimum payment for the test component of a Pap smear at $14.60. Expresses Sense of Congress that HCFA should institute appropriate increases for new cervical cancer screening technologies approved by the FDA.

S. 1788, as reported

Similar payment provision, but does not include the language relating to the sense of Congress.

Agreement

The agreement includes the House provision.

SEC. 225. REFINEMENT OF AMBULANCE SERVICES DEMONSTRATION PROJECT

Current law

BBA 97 authorized a demonstration project under which a unit of local government could enter into a contract with the Secretary to furnish ambulance services for individuals living in the local government unit. Capitated payments in the first year are to equal 95% of the amount which would otherwise be payable. Requires on a capitated basis the Secretary to publish a request for proposals for the project by July 1, 2000. Specifies that the capitation rate is to be based on the most current data and that the aggregate payments do not exceed what would otherwise be paid.

H.R. 3075, as passed

Requires the Secretary to publish a request for proposals for the project by July 1, 2000. Specifies that the capitation rate is to be based on the most current data and that the aggregate payments do not exceed what would otherwise be paid.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision.

SEC. 226. PHASE-IN OF PPS FOR AMBULATORY SURGICAL CENTERS (ASC)

Current law

Medicare payments for services in ASCs have been based on a fee schedule (a form of PPS) since such services were first covered by Medicare in 1982. On June 12, 1998, HCFA published proposed rules rebasing, regrouping, and revising ASC rates which are to be implemented with the hospital outpatient PPS. These new rates are based on 1994 survey data.

H.R. 3075, as passed

For ASC rates based on pre-1999 survey data, requires the new rates to be phased in over a period of at least three years. In the first year, new payment rates cannot exceed ⅓ of the payment totals made to an ASC; in the second year, new payment rates cannot exceed ⅔ of the payment totals made to an ASC.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement note that the data upon which HCFA's proposed payment system is based was collected in 1994 and that there have been substantial changes in costs and technologies associated with these procedures since that time. In addition, the parties to the agreement note that HCFA is now completing a new cost survey intended to yield more reliable information and encourages the Secretary to obtain adequate cost data for rate setting. Should HCFA move forward with its new payment policy, this provision will ensure that the Agency has the flexibility necessary to implement the new ASC system over a period of three years or longer.

SEC. 227. EXTENSION OF MEDICARE BENEFITS FOR IMMUNOSUPPRESSIVE DRUGS

Current law

Medicare pays for drugs used in immunosuppressive therapy during the first 36 months following a Medicare covered organ transplant.

H.R. 3075, as passed

Requires the Secretary to provide for an extension of the 36-month time period. Prohibits any extension after September 30, 2004. Permits the Secretary to limit (or provide priority in) eligibility to those persons who because of income or other factors would be less likely to continue the regimen in the absence of the extension. Limits total expenditures under the extension to $40 million in FY2000 and $200 million overall. Requires a report on the operation of the extension.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision with amendments. The extension would apply to beneficiaries whose benefits under current law expire during the 5-year period beginning January 1, 2000 and ending December 31, 2004. Beneficiaries who current law benefits are set to expire in 2000 would be provided an additional eight months of coverage. Those whose benefits are set to expire in calendar year 2001 would receive a minimum of eight months of additional coverage. Beginning in 2001, the Secretary would be required to compute and specify in May what period of such additional months (which may be portions of months) qualifying beneficiaries would receive in the following year. In May 2001, the Secretary could also extend the period of coverage provided in statute for 2001, if her actuarial estimates supported such an extension. The Secretary is required to compute additional months of coverage in such a manner as to limit total expenditures for the extension to $150 million over the 5-year period. The Secretary would be required to adjust the number of additional months of coverage specified for each year beginning in 2001 and ending 2004 to the extent necessary to take into account differences between actual and estimated expenditures and to assure compliance with the limitation on spending for the extension. The Secretary's computations for any given year is to be based on the best data available to her at the time of computation in the preceeding May. The additional months of coverage established for a given year would apply to an individual who exhausts their 36-month period of coverage during that year. The Secretary's report on the extension would be due March 1, 2003.

SEC. 228. TEMPORARY INCREASE IN PAYMENT AMOUNT FOR DURABLE MEDICAL EQUIPMENT (DME) AND OXYGEN

Current law

The DME fee schedules are updated annually by the CPI–U; BBA 97 eliminated the updates for 1998 through 2002.

H.R. 3075, as passed

Provides an update to the DME payments in 2001 and 2002 by the CPI minus 2 percentage points, for the 12-month period ending with June of the previous year.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision, with a modification to provide temporary adjustments to the DME fee schedule payments equaling 0.3 percent in FY 2001 and 0.6 percent in FY 2002. The Secretary is prohibited from including the additional payments for FY 2001 and 2002 in updates for future years.

SEC. 229. STUDIES AND REPORTS

Current law

No provision.

H.R. 3075, as passed

Requires the following studies: (1) MedPAC study on cost-effectiveness of covering services of a post-surgical recovery center (that provides an intermediate level of recovery care following surgery); (2) AHCPR study comparing differences in the quality of ultrasound and other imaging services provided by credentialed individuals versus those provided by non-credentialed individuals; (3) MedPAC comprehensive study of the regulatory burdens placed on all classes of providers under fee-for-service Medicare and the associated costs; and (4) GAO monitoring of Department of Justice application of guidelines on use of False Claims Act in civil health care matters.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement are concerned that federal regulations governing health care providers participating in the Medicare program are overly complex and administratively burdensome. Therefore, the parties direct MedPAC to conduct a comprehensive study to review the regulatory burdens placed on all classes of health care providers under Parts A and B of the Medicare program. The purpose of the study is to determine the costs these burdens impose on the nation's health care system and the impact on patients and providers, and their ability to deliver cost-effective quality care to Medicare beneficiaries.

The parties to the agreement note that the Congress has expressed concern regarding the application of the False Claims Act (FCA) to Medicare billing errors that are the result of a complex regulatory system. The Department of Justice issued written guidance (''Guidance'') to the United States Attorneys on the appropriate use of the FCA in health care investigations. In 1998, the Congress directed the General Accounting Office (GAO) to monitor the implementation of and compliance with the ''Guidance'' and report to Congress. The provision directs the GAO to continue its monitoring of the issue.

The parties to the agreement request that AHCPR focus its report on the role and the value of credentialing. In designing the study, the Administrator should consult with groups with expertise in ultrasound procedures, including the Society of Diagnostic Medical Sonographers, the Society of Vascular Technology, the American Society of Echocardiography and the American Registry of Diagnostic Medical Sonographers.

TITLE III—PROVISIONS RELATING TO PARTS A AND B

SUBTITLE A—HOME HEALTH SERVICES

SEC. 301. ADJUSTMENT TO REFLECT ADMINISTRATIVE COSTS NOT INCLUDED IN THE INTERIM PAYMENT SYSTEM; GAO REPORT ON COSTS OF COMPLIANCE WITH OASIS DATA COLLECTION REQUIREMENTS

Current law

Home health agency workers are required to collect clinical and social data on new home health patients using the standard Outcome and Assessment Information Set (OASIS) data collection instrument.

H.R. 3075, as passed

Authorizes payments to home health agencies of $10 for each beneficiary served during

a cost reporting period beginning in FY 2000. By April 1, 2000, the Secretary shall pay an estimated 50% of the aggregate annual amount. The payments are to be made from the Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund as determined appropriate by the Secretary. Requires the GAO to report to Congress within 180 days of enactment on the cost of OASIS data collection and the effects on patient privacy. Requires the GAO to perform an audit of the costs of OASIS and report to Congress 180 days after the first cost and privacy report.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision.

SEC. 302. DELAY IN APPLICATION OF 15 PERCENT REDUCTION IN PAYMENT RATES FOR HOME HEALTH SERVICES UNTIL 1 YEAR AFTER IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM (PPS)

Current law

PPS is to be designed to reduce Medicare payments to home health agencies by 15% from pre-PPS payments; if PPS is not implemented by October 1, 2000, payment limits per visit and per beneficiary are to be reduced by 15%.

H.R. 3075, as passed

Delays the 15% reduction in home health payments under the PPS until 12 months after implementation of the PPS. Total Medicare payments to home health agencies in the first year of the PPS shall be the same in total as would have been paid had the PPS not been in effect. The 15% reduction to begin 12 months after the start of the PPS shall be applied to the level of total payments in FY 2001 with updates. Within 6 months of implementation of the PPS, the Secretary shall report to Congress on the need for the 15% or other reduction.

S. 1788, as reported

Repeals the 15% reduction to the interim cost limits if PPS is not ready for implementation on October 1, 2000. Phases in the 15% reduction under the PPS by 5% over 3 years, starting in FY 2001.

Agreement

The agreement includes the House provision. The parties to the agreement encourage the Secretary to consider what changes would be necessary to provide home health care agencies with the flexibility to adopt new market innovations and new technologies that can improve health outcomes while maintaining the goals of quality of care and cost containment. The parties to the agreement also encourage the Secretary to eliminate barriers to the use of branch offices, by allowing the use of technology for means of supervision and oversight by the parent agency. The adequate level of onsite supervision from the parent agency should be determined based on quality outcomes.

SEC. 303. INCREASE IN PER BENEFICIARY LIMITS

Current law

Under the home health care interim payment system established in BBA 97, aggregate payments to home health agencies are computed using the least of reasonable costs, payments based on per visit limits (applied in the aggregate), or payments based on an average payment per beneficiary in FY 1994, with certain updates, applied in the aggregate. No limit applies to individual beneficiaries.

H.R. 3075, as passed

No provision.

S. 1788, as reported

Increases agency per beneficiary limits by 1% starting in October 1, 1999. The increase does not affect per visit limits and is not included in the payment base for establishing the PPS.

Agreement

The agreement includes the Senate provision with an amendment to raise the increase in per beneficiary limits for cost reporting periods beginning during or after FY 2000 by 2% for home health agencies with per beneficiary limits below the national median per beneficiary limit for agencies with cost reporting periods starting during or before FY 1994. This increase will not be included in the base on which payments under the home health PPS are determined.

SEC. 304. CLARIFICATION OF SURETY BOND REQUIREMENTS

Current law

Home health agencies must provide the Secretary on a continuing basis with a surety bond that is not less than $50,000. HCFA regulations require the bond to be not less than 15% of the agency's Medicare payments in the previous year.

H.R. 3075, as passed

Establishes the lesser of $50,000 or 10% of the agency's Medicare payments in the previous year as the annual amount of an agency's surety bond requirement. Requires the bond to be in effect for 4 years, or longer if agency ownership changes; prior periods covered by a bond may be counted. Coordinates Medicare and Medicaid surety bonds.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement encourage the Secretary to provide home health agencies with the opportunity to repay overpayments (due to incorrect interim payment system estimates) over a three-year period without interest costs.

SEC. 305. REFINEMENT OF HOME HEALTH AGENCY CONSOLIDATED BILLING

Current law

When the home health PPS is implemented, home health agencies will be responsible for billing Medicare and paying all other providers for services supplied on behalf of individual home health beneficiaries.

H.R. 3075, as passed

No provision.

S. 1788, as reported

Excludes durable medical equipment, including oxygen and oxygen supplies, from the consolidated billing requirement.

Agreement

The agreement includes the Senate provision.

SEC. 306. TECHNICAL AMENDMENT CLARIFYING APPLICABLE MARKET BASKET INCREASE FOR PROSPECTIVE PAYMENT SYSTEM (PPS)

Current law

When the home health PPS is in effect, the payments are to be updated in FY 2002 ''or'' 2003 by the market basket minus 1.1 percentage points.

H.R. 3075, as passed

Clarifies that the PPS market basket increase minus 1.1 percentage points applies to FY 2002 and FY 2003.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision.

SEC. 307. STUDY AND REPORT TO CONGRESS REGARDING THE EXEMPTION OF RURAL AGENCIES AND POPULATIONS FROM INCLUSION IN THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (PPS)

Current law

No provision.

H.R. 3075, as passed

No provision.

S. 1788, as reported

Requires MedPAC to report to Congress within 2 years on the feasibility and advisability of exempting rural home health agencies or services to individuals residing in rural areas from the home health PPS.

Agreement

The agreement includes the Senate provision.

SUBTITLE B—DIRECT GRADUATE MEDICAL EDUCATION

SEC. 311. USE OF NATIONAL AVERAGE PAYMENT METHODOLOGY IN COMPUTING DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS

Current law

Medicare pays hospitals for its share of direct graduate medical education (DGME) costs in approved training programs using a hospital-specific historic cost per resident, updated for inflation and multiplied by a hospital's number of full-time equivalent (FTE) residents.

H.R. 3075, as passed

Establishes a national average per resident payment amount, adjusted for differences in area wages, starting on or after October 1, 2000. Hospitals would receive the greater of the national average per resident amount or a blended amount of the hospital-specific amount and the national average amount for a transition period for cost reporting periods on or after October 1, 2000 and before October 1, 2004. For cost reports starting on or after October 1, 2004, teaching hospitals would receive Medicare's share of a wage-adjusted national average per resident amount. The national per resident amount would be calculated using each hospital's combined primary care and non-primary care per resident amount, weighted by the number of full time equivalent residents in each hospital with an approved program, and standardized for differences in area wages. The amount would be calculated with data from cost reporting periods ending during FY 1997 updated by the CPI to the midpoint of the FY 2001 cost reporting period. Subsequent updates would be based on the CPI. During the transition period, a hospital with a wage index of less than 1.00 would not have its payment based on the national average adjusted by its area wage index.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision with amendments. This provision establishes a direct graduate medical education payment methodology based on the national average per resident amount modified by the geographic adjustment factor (GAF) used to adjust physician payments, that is the weighted average of the three geographic practice cost indices (GPCIs) weighted by the national average percentage as published in the Federal Register on October 31, 1997. A national average per resident payment amount, based on FY 1997 data, would be calculated from each hospital's combined primary care and non-primary care per resident amounts and would be standardized by the average of the three geographic index values (weighted by the national average weight for each of the work, practice expense, and malpractice components) as applied for 1999 in

the fee schedule in which the hospital is located. The national average per resident amount, standardized for locality, would be calculated using each hospital's amount weighted by the number of FTE residents and would be updated to FY 2001 by the consumer price index for urban areas (CPI).

Beginning during FY 2001, a lower bound would be calculated at 70% of the locality-adjusted, or standardized, national average per resident amount. An upper bound of 140% of the locality-adjusted national average per resident amount also would be calculated. Each hospital's FY 2001 per resident amount would then be compared to the upper and lower bounds adjusted by the GAF for the locality in which the hospital is situated. Hospitals with per resident amounts below 70% of the locality-adjusted threshold would have their per resident amounts increased to the 70% locality-adjusted threshold. Hospitals with per resident amounts that exceed 140% of their locality-adjusted upper bound would receive no update to their per resident amounts for two years (FY 2001 and FY 2002), and would receive updates of CPI minus two percentage points (but not below zero) for three years (FY 2003, FY 2004 and FY 2005). Hospitals with per resident amounts within the locality-adjusted boundaries of 70% and 140% would continue to be paid portions of their per resident amounts and would receive updates for inflation.

The parties to the agreement concur that the GAF seems to be an appropriate measure for adjusting per resident payment amounts, and represents an initial attempt to adjust for differences among geographic areas in the costs related to physician training. The parties to the agreement request that MedPAC study the use of the GAF for this purpose and, if appropriate, make recommendations by March 2002 on the development of a more sophisticated or refined index to adjust payment amounts for physician training.

SEC. 312. INITIAL RESIDENCY PERIOD FOR CHILD NEUROLOGY RESIDENCY TRAINING PROGRAMS

Current law

Each full-time intern and resident is counted as a 1.0 full time equivalent (FTE) resident during the initial residency period. After the initial residency period, a full-time resident can be counted only as 0.5 FTE for Medicare's direct graduate medical education payment. Generally, the initial residency period is the minimum number of years in which a resident must train to be eligible for certification in a medical specialty as listed in the American Medical Association's (AMA) Graduate Medical Education Directory. With a combined primary care specialty program, such as internal medicine-pediatrics, the initial residency period is defined as the minimum number of years for the longer of the two programs, plus one additional year. However, with a combined program where one of the programs is not primary care, then the initial residency period is based on the minimum years to qualify for the longer of the composite programs.

H.R. 3075, as passed

Establishes a 3–year period where an individual in a child neurology residency program shall be treated as part of the initial residency period and shall not be counted against any limitation of the initial residency period.

Requires MedPAC to include in its March 2001 report to Congress a recommendation on whether the initial residency period for other combined residency training programs should be extended.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision with amendment. A resident enrolled in a child neurology residency training program would have a period of board eligibility and initial residency of the board eligibility for pediatrics plus 2 years. This provision would be effective on or after July 1, 2000 to residency programs that began before, on, or after the enactment of this division.

MedPAC would be required to include in its March 2001 report to Congress a recommendation on whether the initial residency period for other combined residency training programs should be extended.

SEC. 321. BBA TECHNICAL CORRECTIONS

H.R. 3075, as passed

Includes various technical corrections to the Balanced Budget Act of 1997.

S. 1788, as reported

Includes various technical corrections to the Balanced Budget Act of 1997.

Agreement

The agreement includes amendments to Medicare law that are needed as a result of the Balanced Budget Act of 1997.

TITLE IV—RURAL PROVIDER PROVISIONS

SUBTITLE A—RURAL HOSPITALS

SEC. 401. PERMITTING RECLASSIFICATION OF CERTAIN URBAN HOSPITALS AS RURAL HOSPITALS

Current law

Medicare's inpatient hospital PPS payments vary by urban/rural classification and the geographic area where a hospital is located or to which a hospital is reassigned. Several mechanisms within the Medicare program permit hospitals that meet certain criteria to apply to the Secretary to change their geographic designation.

H.R. 3075, as passed

Instructs the Secretary to treat certain urban hospitals as rural hospitals no later than 60 days after their application for such treatment if the hospitals: (1) are located in a rural census tract of a Metropolitan Statistical Area (as determined by the Goldsmith Modification published in the Federal Register on February 27, 1992); (2) are located in an area designated by State law or regulation as a rural area or designated by the State as rural providers; or (3) meet other criteria as the Secretary specifies. Permits otherwise qualifying urban hospitals to be classified as sole community hospitals, regional referral centers, rural referral centers, or national referral centers. Extends this rural designation for use in outpatient PPS. Updates other federal criteria used to designate rural providers.

Provides that a hospital in an urban area may apply to the Secretary to be treated as if the hospital were located in a rural area of the State in which the hospital is located. Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. Additionally, qualifying hospitals shall be eligible to apply to the Medicare Geographic Reclassification Review Board for geographic reclassification to another area. The Board shall regard such hospitals as rural and as entitled to the exceptions extended to referral centers and sole community hospitals, if such hospitals are so designated.

S. 1788, as reported

Provides alternative federal criteria to designate providers as rural.

Agreement

The agreement includes the House provision with clarification that the most recent Goldsmith Modification will be used.

SEC. 402. UPDATE OF STANDARDS APPLIED FOR GEOGRAPHIC RECLASSIFICATION FOR CERTAIN HOSPITALS

Current law

Section 1886(d)(8)(B) of the Social Security Act requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban Metropolitan Statistical Area (MSA) to which the greatest number of rural workers commute if the rural county's aggregate commuting rate (to all the contiguous MSAs) meets the standards for designating outlier counties to MSAs (and New England County Metropolitan Statistical Areas) that were published in the Federal Register on January 3, 1980.

H.R. 3075, as passed

Updates the standards which are used to classify hospitals located between two Metropolitan Statistical Areas (MSAs) from 1980 to 1990 census data and then to the most recently available decennial population data for FY 2003 and subsequent years. For FY 2000, the 1980 census data would be used. A transition is provided for discharges occurring during cost report periods during FY 2001 and 2002 for hospitals to choose between the standards published in 1980 and 1990. Beginning with cost reporting periods during FY 2003, standards would be based on the most recent decennial population data published by the Bureau of the Census as revised by the Office of Management and Budget. This provision is effective with discharges occurring during cost reporting periods beginning on or after October 1, 1999.

S. 1788, as reported

No provision.

Agreement

The agreement includes the House provision. The parties to the agreement believe that a transition period for hospitals that might be negatively affected by the change in the standard is appropriate.

SEC. 403. IMPROVEMENTS IN THE CRITICAL ACCESS HOSPITAL (CAH) PROGRAM

Current law

BBA 97 established criteria for a small, rural, limited service hospital to be designated as a critical access hospital (CAH). These are geographically remote, rural nonprofit or public hospitals that are certified by the state as a necessary provider and have hospital stays of no more than 96 hours except under certain circumstances.

H.R. 3075, as passed

Applies the 96-hour length of stay limitation on an average annual basis. Permits forprofit hospitals and hospitals that have closed within the past 10 years to be CAHs. Permits States to designate a facility as a CAH if the facility: (1) was a hospital that ceased operations on or after 10 years before enactment of this legislation; (2) is a State-licensed health clinic or health center; (3) was a hospital that was downsized to a health clinic or health center; and (4) meets the criteria for designation as a CAH. Permits CAHs to elect either a cost-based hospital outpatient service payment plus a fee schedule payment for professional services or an all-inclusive rate. Eliminates coinsurance for clinical laboratory tests. Clarifies CAH's ability to participate in the swing bed program.

S. 1788, as reported

Applies the 96-hour length of stay limitation on an average annual basis.

Agreement

The agreement includes the House provision.